1.1 A bill for an act
1.2 relating to state government; establishing the health and human services budget;
1.3 modifying provisions related to health care, continuing care, nursing facility
1.4 admission, children and family services, human services licensing, chemical and
1.5 mental health, program integrity, managed care organizations, waiver provider
1.6 standards, home care, and the Department of Health; redesigning home and
1.7 community-based services; establishing community first services and supports
1.8 and Northstar Care for Children; providing for fraud investigations in the child
1.9 care assistance program; establishing autism early intensive intervention benefits;
1.10 creating a human services performance council; making technical changes;
1.11 requiring a study; requiring reports; appropriating money; amending Minnesota
1.12 Statutes 2012, sections 16C.10, subdivision 5; 16C.155, subdivision 1; 103I.005,
1.13 by adding a subdivision; 103I.521; 119B.011, by adding a subdivision; 119B.02,
1.14 by adding a subdivision; 119B.025, subdivision 1; 119B.03, subdivision 4;
1.15 119B.05, subdivision 1; 119B.13, subdivisions 1, 1a, 6, by adding subdivisions;
1.16 144.051, by adding subdivisions; 144.0724, subdivision 4; 144.123, subdivision
1.17 1; 144.125, subdivision 1; 144.966, subdivision 2; 144.98, subdivisions 3, 5,
1.18 by adding subdivisions; 144.99, subdivision 4; 144A.351; 144A.43; 144A.44;
1.19 144A.45; 144D.01, subdivision 4; 145.986; 145C.01, subdivision 7; 148E.065,
1.20 subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5, 16, 23, 27, 34, 35, 37, by
1.21 adding subdivisions; 149A.03; 149A.65, by adding subdivisions; 149A.70,
1.22 subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4; 149A.72, subdivisions 3,
1.23 9, by adding a subdivision; 149A.73, subdivisions 1, 2, 4; 149A.74; 149A.90,
1.24 subdivision 8; 149A.91, subdivision 9; 149A.92, subdivision 1; 149A.93,
1.25 subdivisions 3, 6; 149A.94; 149A.96, subdivision 9; 174.30, subdivision 1;
1.26 243.166, subdivisions 4b, 7; 245.4661, subdivisions 5, 6; 245.4682, subdivision
1.27 2; 245A.02, subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 8, 9; 245A.04,
1.28 subdivision 13; 245A.042, subdivision 3; 245A.07, subdivisions 2a, 3; 245A.08,
1.29 subdivision 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435;
1.30 245A.144; 245A.1444; 245A.16, subdivision 1; 245A.40, subdivision 5;
1.31 245A.50; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245C.33,
1.32 subdivision 1; 245D.02; 245D.03; 245D.04; 245D.05; 245D.06; 245D.07;
1.33 245D.09; 245D.10; 246.18, subdivision 8, by adding a subdivision; 246.54;
1.34 254B.04, subdivision 1; 256.01, subdivisions 2, 24, 34, by adding subdivisions;
1.35 256.0112, by adding a subdivision; 256.82, subdivisions 2, 3; 256.969,
1.36 subdivision 3a; 256.975, subdivision 7, by adding subdivisions; 256.9754,
1.37 subdivision 5, by adding subdivisions; 256.98, subdivision 8; 256B.02, by
1.38 adding subdivisions; 256B.021, by adding subdivisions; 256B.04, subdivisions
1.39 18, 21, by adding a subdivision; 256B.055, subdivisions 3a, 6, 10, 15, by adding

2.1 subdivisions; 256B.056, subdivisions 1, 1a, 1c, 3, 3c, 4, 5c, 10, by adding a
2.2 subdivision; 256B.057, subdivisions 1, 8, 10, by adding a subdivision; 256B.059,
2.3 subdivision 1; 256B.06, subdivision 4; 256B.0625, subdivisions 13e, 17a, 19c,
2.4 31, 39, 58, by adding subdivisions; 256B.064, subdivisions 1a, 1b, 2; 256B.0659,
2.5 subdivision 21; 256B.0911, subdivisions 1, 1a, 3a, 4d, 6, 7, by adding a
2.6 subdivision; 256B.0913, subdivision 4, by adding a subdivision; 256B.0915,
2.7 subdivisions 3a, 5, by adding a subdivision; 256B.0916, by adding a subdivision;
2.8 256B.0917, subdivisions 6, 13, by adding subdivisions; 256B.092, subdivisions
2.9 11, 12, by adding subdivisions; 256B.0946; 256B.434, subdivision 4; 256B.437,
2.10 subdivision 6; 256B.439, subdivisions 1, 2, 3, 4, by adding a subdivision;
2.11 256B.441, subdivisions 13, 53, by adding subdivisions; 256B.49, subdivisions
2.12 11a, 12, 14, 15, by adding subdivisions; 256B.4912, subdivisions 1, 7, by adding
2.13 subdivisions; 256B.493, subdivision 2; 256B.5011, subdivision 2; 256B.69,
2.14 subdivisions 5c, 31; 256B.76, subdivisions 1, 2, by adding a subdivision;
2.15 256B.761; 256B.764; 256B.766; 256I.05, by adding a subdivision; 256J.08,
2.16 subdivision 24; 256J.21, subdivisions 2, 3; 256J.24, subdivisions 3, 7; 256J.621;
2.17 256J.626, subdivision 7; 256L.01, subdivisions 3a, 5, by adding a subdivision;
2.18 256L.02, subdivision 2; 256L.03, subdivisions 1, 1a, 3, 5; 256L.04, subdivisions
2.19 1, 7, 8, 10, 12, by adding a subdivision; 256L.05, subdivision 3; 256L.06,
2.20 subdivision 3; 256L.07, subdivisions 1, 2, 3; 256L.09, subdivision 2; 256L.11,
2.21 subdivision 6; 256L.15, subdivisions 1, 2; 257.85, subdivisions 2, 5, 6; 260C.446;
2.22 402A.10; 402A.18; 471.59, subdivision 1; 626.556, subdivisions 2, 3, 10d;
2.23 626.557, subdivisions 4, 9, 9a, 9e; 626.5572, subdivision 13; Laws 1998, chapter
2.24 407, article 6, section 116; proposing coding for new law in Minnesota Statutes,
2.25 chapters 144; 144A; 149A; 245; 245A; 245D; 256; 256B; 256J; 259A; 260C;
2.26 402A; proposing coding for new law as Minnesota Statutes, chapters 245E; 256N;
2.27 repealing Minnesota Statutes 2012, sections 103I.005, subdivision 20; 144.123,
2.28 subdivision 2; 144A.46; 144A.461; 149A.025; 149A.20, subdivision 8; 149A.30,
2.29 subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6; 149A.50,
2.30 subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53,
2.31 subdivision 9; 245A.655; 245B.01; 245B.02; 245B.03; 245B.031; 245B.04;
2.32 245B.05, subdivisions 1, 2, 3, 5, 6, 7; 245B.055; 245B.06; 245B.07; 245B.08;
2.33 245D.08; 256.82, subdivision 4; 256B.055, subdivisions 3, 5, 10b; 256B.056,
2.34 subdivision 5b; 256B.057, subdivisions 1c, 2; 256B.0911, subdivisions 4a,
2.35 4b, 4c; 256B.0917, subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.49,
2.36 subdivision 16a; 256B.5012, subdivision 13; 256J.24, subdivision 10; 256L.01,
2.37 subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, 10a; 256L.05, subdivision
2.38 3b; 256L.07, subdivisions 5, 8, 9; 256L.11, subdivision 5; 256L.17; 260C.441;
2.39 485.14; Laws 2011, First Special Session chapter 9, article 7, section 54, as
2.40 amended; Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008;
2.41 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035;
2.42 4668.0040; 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075;
2.43 4668.0080; 4668.0100; 4668.0110; 4668.0120; 4668.0130; 4668.0140;
2.44 4668.0150; 4668.0160; 4668.0170; 4668.0180; 4668.0190; 4668.0200;
2.45 4668.0218; 4668.0220; 4668.0230; 4668.0240; 4668.0800; 4668.0805;
2.46 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830; 4668.0835;
2.47 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870;
2.48 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; 4669.0050;
2.49 9502.0355, subpart 4; 9560.0650, subparts 1, 3, 6; 9560.0651; 9560.0655.

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

ARTICLE 1

AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH CARE FOR MORE MINNESOTANS

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

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

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

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

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

4.1 money appropriated for this paragraph must be placed in a separate account established
4.2 for this purpose.

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

4.5 (a) The commissioner of human services shall seek federal authority from the
4.6 United States Department of Health and Human Services necessary to operate a health
4.7 insurance program for Minnesotans with incomes up to 275 percent of the federal poverty
4.8 guidelines (FPG). The proposal shall seek to secure all funding available from at least the
4.9 following services:

4.10 (1) all premium tax credits and cost-sharing subsidies available under United States
4.11 Code, title 26, section 36B, and United States Code, title 42, section 18071, for individuals
4.12 with incomes above 133 percent and at or below 275 percent of FPG who would otherwise
4.13 be enrolled in the Health Insurance Exchange;

4.14 (2) Medicaid funding; and

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

4.17 (b) Funding received must be used to design and implement a health insurance
4.18 program that creates a single streamlined program and meets the needs of Minnesotans
4.19 with incomes up to 275 percent of FPG and shall incorporate:

4.20 (1) payment reform characteristics included in the Health Care Delivery System and
4.21 Accountable Care Organization payment models;

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

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

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

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

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

5.1 (e) The commissioner shall report to the chairs and ranking minority members
5.2 of the legislative committees with jurisdiction over health and human services finance
5.3 and policy by December 1, 2014.
5.4 (f) The commissioner is authorized to accept and expend federal funds that support
5.5 the purposes of this section.

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

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

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

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

5.19 Sec. 5. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
5.20 to read:
5.21 Subd. 19. **Insurance affordability program.** "Insurance affordability program"
5.22 means one of the following programs:
5.23 (1) medical assistance under this chapter;
5.24 (2) a program that provides advance payments of the premium tax credits established
5.25 under section 36B of the Internal Revenue Code or cost-sharing reductions established
5.26 under section 1402 of the Affordable Care Act;
5.27 (3) MinnesotaCare as defined in chapter 256L; and
5.28 (4) a Basic Health Plan as defined in section 1331 of the Affordable Care Act.

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

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

6.1 Subd. 18. **Applications for medical assistance.** (a) The state agency ~~may take~~
6.2 shall accept applications for medical assistance ~~and conduct eligibility determinations for~~
6.3 ~~MinnesotaCare enrollees~~ by telephone, via mail, in-person, online via an Internet Web
6.4 site, and through other commonly available electronic means.
6.5 (b) The commissioner of human services shall modify the Minnesota health care
6.6 programs application form to add a question asking applicants whether they have ever
6.7 served in the United States military.
6.8 (c) For each individual who submits an application or whose eligibility is subject to
6.9 renewal or whose eligibility is being redetermined pursuant to a change in circumstances,
6.10 if the agency determines the individual is not eligible for medical assistance, the agency
6.11 shall determine potential eligibility for other insurance affordability programs.

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

6.13 Sec. 7. Minnesota Statutes 2012, section 256B.055, subdivision 3a, is amended to read:
6.14 Subd. 3a. **Families with children.** ~~Beginning July 1, 2002,~~ Medical assistance may
6.15 be paid for a person who is a child under the age of ~~18, or age 18 if a full-time student~~
6.16 ~~in a secondary school, or in the equivalent level of vocational or technical training, and~~
6.17 ~~reasonably expected to complete the program before reaching age~~ 19; the parent or
6.18 stepparent of a ~~dependent~~ child under the age of 19, including a pregnant woman; or a
6.19 caretaker relative of a ~~dependent~~ child under the age of 19.

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

6.23 Sec. 8. Minnesota Statutes 2012, section 256B.055, subdivision 6, is amended to read:
6.24 Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid
6.25 for a pregnant woman who ~~has written verification of a positive pregnancy test from a~~
6.26 ~~physician or licensed registered nurse, who~~ meets the other eligibility criteria of this
6.27 section and whose unborn child would be eligible as a needy child under subdivision 10 if
6.28 born and living with the woman. In accordance with Code of Federal Regulations, title
6.29 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless
6.30 the agency has information that is not reasonably compatible with such attestation. For
6.31 purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

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

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

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

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

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

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

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

7.13 (2) not pregnant;

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

7.16 (4) ~~not an adult in a family with children as defined in section 256L.01, subdivision~~
7.17 ~~3a; and~~ not otherwise eligible under subdivision 7 as a person who meets the categorical
7.18 eligibility requirements of the supplemental security income program;

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

7.22 ~~(5)~~ (6) not described in another subdivision of this section.

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

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

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

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

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

7.31 Subd. 17. **Adults who were in foster care at the age of 18.** Medical assistance may
7.32 be paid for a person under 26 years of age who was in foster care under the commissioner's

8.1 responsibility on the date of attaining 18 years of age, and who was enrolled in medical
8.2 assistance under the state plan or a waiver of the plan while in foster care, in accordance
8.3 with section 2004 of the Affordable Care Act.

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

8.5 Sec. 13. Minnesota Statutes 2012, section 256B.056, subdivision 1, is amended to read:
8.6 Subdivision 1. **Residency.** To be eligible for medical assistance, a person must
8.7 reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota,
8.8 in accordance with ~~the rules of the state agency~~ Code of Federal Regulations, title 42,
8.9 section 435.403.

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

8.11 Sec. 14. Minnesota Statutes 2012, section 256B.056, subdivision 1a, is amended to read:
8.12 Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by
8.13 state law or rule or federal law or regulation, the methodologies used in counting income
8.14 and assets to determine eligibility for medical assistance for persons whose eligibility
8.15 category is based on blindness, disability, or age of 65 or more years, the methodologies
8.16 for the supplemental security income program shall be used, except as provided under
8.17 subdivision 3, paragraph (a), clause (6).
8.18 (2) Increases in benefits under title II of the Social Security Act shall not be counted
8.19 as income for purposes of this subdivision until July 1 of each year. Effective upon federal
8.20 approval, for children eligible under section 256B.055, subdivision 12, or for home and
8.21 community-based waiver services whose eligibility for medical assistance is determined
8.22 without regard to parental income, child support payments, including any payments
8.23 made by an obligor in satisfaction of or in addition to a temporary or permanent order
8.24 for child support, and Social Security payments are not counted as income. ~~For families~~
8.25 ~~and children, which includes all other eligibility categories, the methodologies under the~~
8.26 ~~state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility~~
8.27 ~~and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193,~~
8.28 ~~shall be used, except that effective October 1, 2003, the earned income disregards and~~
8.29 ~~deductions are limited to those in subdivision 1c.~~
8.30 (b)(1) The modified adjusted gross income methodology as defined in the Affordable
8.31 Care Act shall be used for eligibility categories based on:
8.32 (i) children under age 19 and their parents and relative caretakers as defined in
8.33 section 256B.055, subdivision 3a;

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

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

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

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

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

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

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

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

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

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

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

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

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

10.1 earner's income has not been considered in determining medical assistance eligibility for
10.2 12 consecutive months.
10.3 (d) The commissioner shall adjust the income standards under this section each July
10.4 1 by the annual update of the federal poverty guidelines following publication by the
10.5 United States Department of Health and Human Services except that the income standards
10.6 shall not go below those in effect on July 1, 2009.
10.7 (e) For children age 18 or under, annual gifts of $2,000 or less by a tax-exempt
10.8 organization to or for the benefit of the child with a life-threatening illness must be
10.9 disregarded from income.

10.10 Sec. 16. Minnesota Statutes 2012, section 256B.056, subdivision 3, is amended to read:
10.11 Subd. 3. **Asset limitations for <u>certain</u> individuals ~~and families~~.** ~~(a)~~ To be
10.12 eligible for medical assistance, a person must not individually own more than $3,000 in
10.13 assets, or if a member of a household with two family members, husband and wife, or
10.14 parent and child, the household must not own more than $6,000 in assets, plus $200 for
10.15 each additional legal dependent. In addition to these maximum amounts, an eligible
10.16 individual or family may accrue interest on these amounts, but they must be reduced to the
10.17 maximum at the time of an eligibility redetermination. The accumulation of the clothing
10.18 and personal needs allowance according to section 256B.35 must also be reduced to the
10.19 maximum at the time of the eligibility redetermination. The value of assets that are not
10.20 considered in determining eligibility for medical assistance is the value of those assets
10.21 excluded under the supplemental security income program for aged, blind, and disabled
10.22 persons, with the following exceptions:
10.23 (1) household goods and personal effects are not considered;
10.24 (2) capital and operating assets of a trade or business that the local agency determines
10.25 are necessary to the person's ability to earn an income are not considered;
10.26 (3) motor vehicles are excluded to the same extent excluded by the supplemental
10.27 security income program;
10.28 (4) assets designated as burial expenses are excluded to the same extent excluded by
10.29 the supplemental security income program. Burial expenses funded by annuity contracts
10.30 or life insurance policies must irrevocably designate the individual's estate as contingent
10.31 beneficiary to the extent proceeds are not used for payment of selected burial expenses;
10.32 (5) for a person who no longer qualifies as an employed person with a disability due
10.33 to loss of earnings, assets allowed while eligible for medical assistance under section
10.34 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month

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

11.3 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
11.4 9, is age 65 or older and has been enrolled during each of the 24 consecutive months
11.5 before the person's 65th birthday, the assets owned by the person and the person's spouse
11.6 must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d),
11.7 when determining eligibility for medical assistance under section 256B.055, subdivision
11.8 7. The income of a spouse of a person enrolled in medical assistance under section
11.9 256B.057, subdivision 9, during each of the 24 consecutive months before the person's
11.10 65th birthday must be disregarded when determining eligibility for medical assistance
11.11 under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to
11.12 the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013
11.13 is required to have qualified for medical assistance under section 256B.057, subdivision 9,
11.14 prior to age 65 for at least 20 months in the 24 months prior to reaching age 65; and

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

11.19 ~~(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision~~
11.20 ~~15.~~

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

11.22 Sec. 17. Minnesota Statutes 2012, section 256B.056, subdivision 3c, is amended to read:

11.23 Subd. 3c. **Asset limitations for families and children.** (a) A household of two or
11.24 more persons must not own more than $20,000 in total net assets, and a household of one
11.25 person must not own more than $10,000 in total net assets. In addition to these maximum
11.26 amounts, an eligible individual or family may accrue interest on these amounts, but they
11.27 must be reduced to the maximum at the time of an eligibility redetermination. The value of
11.28 assets that are not considered in determining eligibility for medical assistance for families
11.29 and children is the value of those assets excluded under the AFDC state plan as of July 16,
11.30 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation
11.31 Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

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

11.33 (2) capital and operating assets of a trade or business up to $200,000 are not
11.34 considered, except that a bank account that contains personal income or assets, or is used to
11.35 pay personal expenses, is not considered a capital or operating asset of a trade or business;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered;

(7) assets owned by children are not considered; and

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

The assets specified in clause (2) must be disclosed to the local agency at the time of application and at the time of an eligibility redetermination, and must be verified upon request of the local agency.

<u>(b) Beginning January 1, 2014, this subdivision applies only to parents and caretaker relatives who qualify for medical assistance under subdivision 5.</u>

<u>**EFFECTIVE DATE.**</u> <u>This section is effective January 1, 2014.</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the commissioner must provide the enrollee with a prepopulated renewal form containing eligibility information available to the agency and permit the enrollee to submit the form

with any corrections or additional information to the agency and sign the renewal form via any of the modes of submission specified in section 256B.04, subdivision 18.

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

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

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

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

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

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

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

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

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

Sec. 22. Minnesota Statutes 2012, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **Infants and pregnant women.** (a)~~(1)~~ An infant less than ~~one year~~ two years of age or a pregnant woman ~~who has written verification of a positive pregnancy test from a physician or licensed registered nurse~~ is eligible for medical assistance if the

15.1 individual's countable ~~family~~ household income is equal to or less than 275 percent of the
15.2 federal poverty guideline for the same ~~family~~ household size or an equivalent standard
15.3 when converted using modified adjusted gross income methodology as required under
15.4 the Affordable Care Act. ~~For purposes of this subdivision, "countable family income"~~
15.5 ~~means the amount of income considered available using the methodology of the AFDC~~
15.6 ~~program under the state's AFDC plan as of July 16, 1996, as required by the Personal~~
15.7 ~~Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public~~
15.8 ~~Law 104-193, except for the earned income disregard and employment deductions.~~
15.9 ~~(2) For applications processed within one calendar month prior to the effective date,~~
15.10 ~~eligibility shall be determined by applying the income standards and methodologies in~~
15.11 ~~effect prior to the effective date for any months in the six-month budget period before~~
15.12 ~~that date and the income standards and methodologies in effect on the effective date for~~
15.13 ~~any months in the six-month budget period on or after that date. The income standards~~
15.14 ~~for each month shall be added together and compared to the applicant's total countable~~
15.15 ~~income for the six-month budget period to determine eligibility.~~
15.16 ~~(b)(1) [Expired, 1Sp2003 c 14 art 12 s 19]~~
15.17 ~~(2) For applications processed within one calendar month prior to July 1, 2003,~~
15.18 ~~eligibility shall be determined by applying the income standards and methodologies in~~
15.19 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July 1,~~
15.20 ~~2003, and the income standards and methodologies in effect on the expiration date for any~~
15.21 ~~months in the six-month budget period on or after July 1, 2003. The income standards~~
15.22 ~~for each month shall be added together and compared to the applicant's total countable~~
15.23 ~~income for the six-month budget period to determine eligibility.~~
15.24 ~~(3) An amount equal to the amount of earned income exceeding 275 percent of~~
15.25 ~~the federal poverty guideline, up to a maximum of the amount by which the combined~~
15.26 ~~total of 185 percent of the federal poverty guideline plus the earned income disregards~~
15.27 ~~and deductions allowed under the state's AFDC plan as of July 16, 1996, as required~~
15.28 ~~by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public~~
15.29 ~~Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for~~
15.30 ~~pregnant women and infants less than one year of age.~~
15.31 ~~(c) Dependent care and child support paid under court order shall be deducted from~~
15.32 ~~the countable income of pregnant women.~~
15.33 ~~(d)~~ (b) An infant born to a woman who was eligible for and receiving medical
15.34 assistance on the date of the child's birth shall continue to be eligible for medical assistance
15.35 without redetermination until the child's first birthday.

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

16.1 Sec. 23. Minnesota Statutes 2012, section 256B.057, subdivision 8, is amended to read:

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

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

16.8 Sec. 24. Minnesota Statutes 2012, section 256B.057, subdivision 10, is amended to read:

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

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

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

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

16.19 (4) is under age 65;

16.20 (5) is not otherwise eligible for medical assistance under United States Code, title
16.21 42, section 1396a(a)(10)(A)(i); and

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

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

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

16.30 Sec. 25. Minnesota Statutes 2012, section 256B.057, is amended by adding a
16.31 subdivision to read:

16.32 Subd. 12. **Presumptive eligibility determinations made by qualified hospitals.**
16.33 The commissioner shall establish a process to qualify hospitals that are participating
16.34 providers under the medical assistance program to determine presumptive eligibility for

17.1 <u>medical assistance for applicants who may have a basis of eligibility using the modified</u>
17.2 <u>adjusted gross income methodology as defined in section 256B.056, subdivision 1a,</u>
17.3 <u>paragraph (b), clause (1).</u>

17.4 <u>**EFFECTIVE DATE.**</u> <u>This section is effective January 1, 2014.</u>

17.5 Sec. 26. Minnesota Statutes 2012, section 256B.059, subdivision 1, is amended to read:
17.6 Subdivision 1. **Definitions.** (a) For purposes of this section and sections 256B.058
17.7 and 256B.0595, the terms defined in this subdivision have the meanings given them.
17.8 (b) "Community spouse" means the spouse of an institutionalized spouse.
17.9 (c) "Spousal share" means one-half of the total value of all assets, to the extent that
17.10 either the institutionalized spouse or the community spouse had an ownership interest at
17.11 the time of the first continuous period of institutionalization.
17.12 (d) "Assets otherwise available to the community spouse" means assets individually
17.13 or jointly owned by the community spouse, other than assets excluded by subdivision 5,
17.14 paragraph (c).
17.15 (e) "Community spouse asset allowance" is the value of assets that can be transferred
17.16 under subdivision 3.
17.17 (f) "Institutionalized spouse" means a person who is:
17.18 (1) in a hospital, nursing facility, or intermediate care facility for persons with
17.19 developmental disabilities, or receiving home and community-based services under section
17.20 256B.0915<u>, 256B.092, or 256B.49</u> and is expected to remain in the facility or institution
17.21 or receive the home and community-based services for at least 30 consecutive days; and
17.22 (2) married to a person who is not in a hospital, nursing facility, or intermediate
17.23 care facility for persons with developmental disabilities, and is not receiving home and
17.24 community-based services under section 256B.0915, 256B.092, or 256B.49.
17.25 (g) "For the sole benefit of" means no other individual or entity can benefit in any
17.26 way from the assets or income at the time of a transfer or at any time in the future.
17.27 (h) "Continuous period of institutionalization" means a 30-consecutive-day period
17.28 of time in which a person is expected to stay in a medical or long-term care facility, or
17.29 receive home and community-based services that would qualify for coverage under ~~the~~
17.30 ~~elderly waiver (EW) or alternative care (AC) programs~~ <u>section 256B.0913, 256B.0915,</u>
17.31 <u>256B.092, or 256B.49</u>. For a stay in a facility, the 30-consecutive-day period begins
17.32 on the date of entry into a medical or long-term care facility. For receipt of home and
17.33 community-based services, the 30-consecutive-day period begins on the date that the
17.34 following conditions are met:

(1) the person is receiving services that meet the nursing facility level of care determined by a long-term care consultation;

(2) the person has received the long-term care consultation within the past 60 days;

(3) the services are paid ~~by the EW program~~ under section ~~256B.0915 or the AC program under section~~ 256B.0913, 256B.0915, 256B.092, or 256B.49 or would qualify for payment under ~~the EW or AC programs~~ those sections if the person were otherwise eligible for either program, and but for the receipt of such services the person would have resided in a nursing facility; and

(4) the services are provided by a licensed provider qualified to provide home and community-based services.

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

Sec. 27. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant

19.1 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
19.2 Public Law 104-200; or

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

19.5 (c) All qualified noncitizens who were residing in the United States before August
19.6 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
19.7 medical assistance with federal financial participation.

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

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

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

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

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

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

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

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

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

20.1 (g) For purposes of this subdivision, the term "emergency medical condition" means
20.2 a medical condition that meets the requirements of United States Code, title 42, section
20.3 1396b(v).
20.4 (h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment
20.5 of an emergency medical condition are limited to the following:
20.6 (i) services delivered in an emergency room or by an ambulance service licensed
20.7 under chapter 144E that are directly related to the treatment of an emergency medical
20.8 condition;
20.9 (ii) services delivered in an inpatient hospital setting following admission from an
20.10 emergency room or clinic for an acute emergency condition; and
20.11 (iii) follow-up services that are directly related to the original service provided
20.12 to treat the emergency medical condition and are covered by the global payment made
20.13 to the provider.
20.14 (2) Services for the treatment of emergency medical conditions do not include:
20.15 (i) services delivered in an emergency room or inpatient setting to treat a
20.16 nonemergency condition;
20.17 (ii) organ transplants, stem cell transplants, and related care;
20.18 (iii) services for routine prenatal care;
20.19 (iv) continuing care, including long-term care, nursing facility services, home health
20.20 care, adult day care, day training, or supportive living services;
20.21 (v) elective surgery;
20.22 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as
20.23 part of an emergency room visit;
20.24 (vii) preventative health care and family planning services;
20.25 (viii) dialysis;
20.26 (ix) chemotherapy or therapeutic radiation services;
20.27 (x) rehabilitation services;
20.28 (xi) physical, occupational, or speech therapy;
20.29 (xii) transportation services;
20.30 (xiii) case management;
20.31 (xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
20.32 (xv) dental services;
20.33 (xvi) hospice care;
20.34 (xvii) audiology services and hearing aids;
20.35 (xviii) podiatry services;
20.36 (xix) chiropractic services;

21.1 (xx) immunizations;

21.2 (xxi) vision services and eyeglasses;

21.3 (xxii) waiver services;

21.4 (xxiii) individualized education programs; or

21.5 (xxiv) chemical dependency treatment.

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

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

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

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

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

21.31 Subd. 1b. **Affordable Care Act.** "Affordable Care Act" means Public Law 111-148,
21.32 as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public
21.33 Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 2. **Commissioner's duties.** The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all eligible providers. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services. A toll-free telephone number and Web site must be used to provide information about medical programs and to promote access to the covered services.

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

Sec. 32. Minnesota Statutes 2012, section 256L.03, subdivision 1, is amended to read:

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

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

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

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

Sec. 33. Minnesota Statutes 2012, section 256L.03, subdivision 1a, is amended to read:

Subd. 1a. ~~**Pregnant women and**~~ **Children; MinnesotaCare health care reform waiver.** ~~Beginning January 1, 1999,~~ Children ~~and pregnant women~~ are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except that abortion services under MinnesotaCare shall be

24.1 limited as provided under subdivision 1. ~~Pregnant women and~~ Children are exempt from
24.2 the provisions of subdivision 5, regarding co-payments. ~~Pregnant women and~~ Children
24.3 who are lawfully residing in the United States but who are not "qualified noncitizens" under
24.4 title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,
24.5 Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage
24.6 of all services provided under the medical assistance program according to chapter 256B.

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

24.10 Sec. 34. Minnesota Statutes 2012, section 256L.03, subdivision 3, is amended to read:
24.11 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
24.12 inpatient hospital services, including inpatient hospital mental health services and inpatient
24.13 hospital and residential chemical dependency treatment, subject to those limitations
24.14 necessary to coordinate the provision of these services with eligibility under the medical
24.15 assistance spenddown. ~~The inpatient hospital benefit for adult enrollees who qualify under~~
24.16 ~~section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and~~
24.17 ~~2, with family gross income that exceeds 200 percent of the federal poverty guidelines or~~
24.18 ~~215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not~~
24.19 ~~pregnant, is subject to an annual limit of $10,000.~~
24.20 (b) Admissions for inpatient hospital services paid for under section 256L.11,
24.21 subdivision 3, must be certified as medically necessary in accordance with Minnesota
24.22 Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):
24.23 (1) all admissions must be certified, except those authorized under rules established
24.24 under section 254A.03, subdivision 3, or approved under Medicare; and
24.25 (2) payment under section 256L.11, subdivision 3, shall be reduced by five percent
24.26 for admissions for which certification is requested more than 30 days after the day of
24.27 admission. The hospital may not seek payment from the enrollee for the amount of the
24.28 payment reduction under this clause.

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

24.32 Sec. 35. Minnesota Statutes 2012, section 256L.03, subdivision 5, is amended to read:

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

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

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

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

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

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

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

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

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

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

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

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. 36. Minnesota Statutes 2012, section 256L.04, subdivision 1, is amended to read:
26.7 Subdivision 1. **Families with children.** ~~(a)~~ Families with children with family
26.8 income above 133 percent of the federal poverty guidelines and equal to or less than
26.9 ~~275~~ 200 percent of the federal poverty guidelines for the applicable family size shall be
26.10 eligible for MinnesotaCare according to this section. All other provisions of sections
26.11 256L.01 to 256L.18~~, including the insurance-related barriers to enrollment under section~~
26.12 ~~256L.07,~~ shall apply unless otherwise specified.
26.13 ~~(b) Parents who enroll in the MinnesotaCare program must also enroll their children,~~
26.14 ~~if the children are eligible. Children may be enrolled separately without enrollment by~~
26.15 ~~parents. However, if one parent in the household enrolls, both parents must enroll, unless~~
26.16 ~~other insurance is available. If one child from a family is enrolled, all children must~~
26.17 ~~be enrolled, unless other insurance is available. If one spouse in a household enrolls,~~
26.18 ~~the other spouse in the household must also enroll, unless other insurance is available.~~
26.19 ~~Families cannot choose to enroll only certain uninsured members.~~
26.20 ~~(c) Beginning October 1, 2003, the dependent sibling definition no longer applies~~
26.21 ~~to the MinnesotaCare program. These persons are no longer counted in the parental~~
26.22 ~~household and may apply as a separate household.~~
26.23 ~~(d) Parents are not eligible for MinnesotaCare if their gross income exceeds $57,500.~~
26.24 ~~(e) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision~~
26.25 ~~8, are exempt from the eligibility requirements of this subdivision.~~

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

26.29 Sec. 37. Minnesota Statutes 2012, section 256L.04, subdivision 7, is amended to read:
26.30 Subd. 7. **Single adults and households with no children.** ~~(a)~~ The definition of
26.31 eligible persons includes all individuals and ~~households~~ families with no children who
26.32 have ~~gross family~~ incomes that are above 133 percent and equal to or less than 200 percent
26.33 of the federal poverty guidelines for the applicable family size.

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

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. 38. Minnesota Statutes 2012, section 256L.04, subdivision 8, is amended to read:
27.8 Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals
27.9 who receive supplemental security income or retirement, survivors, or disability benefits
27.10 due to a disability, or other disability-based pension, who qualify under subdivision 7, but
27.11 who are potentially eligible for medical assistance without a spenddown shall be allowed
27.12 to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other
27.13 conditions of eligibility. The commissioner shall identify and refer the applications of
27.14 such individuals to their county social service agency. The county and the commissioner
27.15 shall cooperate to ensure that the individuals obtain medical assistance coverage for any
27.16 months for which they are eligible.
27.17 (b) The enrollee must cooperate with the county social service agency in determining
27.18 medical assistance eligibility within the 60-day enrollment period. Enrollees who do not
27.19 cooperate with medical assistance within the 60-day enrollment period shall be disenrolled
27.20 from the plan within one calendar month. Persons disenrolled for nonapplication for
27.21 medical assistance may not reenroll until they have obtained a medical assistance
27.22 eligibility determination. Persons disenrolled for noncooperation with medical assistance
27.23 may not reenroll until they have cooperated with the county agency and have obtained a
27.24 medical assistance eligibility determination.
27.25 (c) Beginning January 1, 2000, counties that choose to become MinnesotaCare
27.26 enrollment sites shall consider MinnesotaCare applications to also be applications for
27.27 medical assistance. ~~Applicants who are potentially eligible for medical assistance, except~~
27.28 ~~for those described in paragraph (a), may choose to enroll in either MinnesotaCare or~~
27.29 ~~medical assistance.~~
27.30 (d) The commissioner shall redetermine provider payments made under
27.31 MinnesotaCare to the appropriate medical assistance payments for those enrollees who
27.32 subsequently become eligible for medical assistance.

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

28.4 Sec. 39. Minnesota Statutes 2012, section 256L.04, subdivision 10, is amended to read:
28.5 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to
28.6 citizens or nationals of the United States~~, qualified noncitizens, and other persons residing~~
28.7 and lawfully ~~in the United States~~ present noncitizens as defined in Code of Federal
28.8 Regulations, title 8, section 103.12. Undocumented noncitizens ~~and nonimmigrants~~
28.9 are ineligible for MinnesotaCare. For purposes of this subdivision, ~~a nonimmigrant~~
28.10 ~~is an individual in one or more of the classes listed in United States Code, title 8,~~
28.11 ~~section 1101(a)(15), and~~ an undocumented noncitizen is an individual who resides in the
28.12 United States without the approval or acquiescence of the United States Citizenship and
28.13 Immigration Services. Families with children who are citizens or nationals of the United
28.14 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
28.15 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
28.16 Public Law 109-171.
28.17 (b) Eligible persons include individuals who are lawfully present and ineligible for
28.18 medical assistance by reason of immigration status, who have family income equal to or
28.19 less than 200 percent of the federal poverty guidelines for the applicable family size.

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. 40. Minnesota Statutes 2012, section 256L.04, subdivision 12, is amended to read:
28.24 Subd. 12. **Persons in detention.** Beginning January 1, 1999, an applicant or enrollee
28.25 residing in a correctional or detention facility is not eligible for MinnesotaCare. ~~An~~
28.26 ~~enrollee residing in a correctional or detention facility is not eligible at renewal of eligibility~~
28.27 ~~under section 256L.05, subdivision 3a.~~ Applicants or enrollees residing in a correctional
28.28 or detention facility pending disposition of charges are eligible for MinnesotaCare.

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

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

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

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

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

29.10 Sec. 42. Minnesota Statutes 2012, section 256L.05, subdivision 3, is amended to read:

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

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

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

29.26 ~~(d)~~ (c) Notwithstanding any other law to the contrary, benefits under sections
29.27 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which
29.28 an eligible person may have coverage and the commissioner shall use cost avoidance
29.29 techniques to ensure coordination of any other health coverage for eligible persons. The
29.30 commissioner shall identify eligible persons who may have coverage or benefits under
29.31 other plans of insurance or who become eligible for medical assistance.

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

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

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

Sec. 43. Minnesota Statutes 2012, section 256L.06, subdivision 3, is amended to read:

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

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

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

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

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

Sec. 44. Minnesota Statutes 2012, section 256L.07, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 45. Minnesota Statutes 2012, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized minimum essential coverage.** (a) To be eligible, a family or individual must not have access to subsidized

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

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

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

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

Sec. 46. Minnesota Statutes 2012, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) ~~Families and individuals enrolled in the MinnesotaCare program must have no~~ To be eligible, a family or individual must not have minimum essential health coverage ~~while enrolled~~, as defined by section 5000A of the Internal Revenue Code. ~~Children with family gross incomes equal to or greater than 200 percent of federal poverty guidelines, and adults, must have had no health coverage for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 200 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:~~

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

~~(i) basic hospital insurance;~~

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

~~(iii) prescription drug coverage;~~

~~(iv) dental coverage; or~~

~~(v) vision coverage;~~

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

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

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

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

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

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

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

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

Sec. 47. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

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

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

Sec. 48. Minnesota Statutes 2012, section 256L.11, subdivision 6, is amended to read:

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

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

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

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

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

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

~~(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the~~

~~commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.~~

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

Sec. 49. Minnesota Statutes 2012, section 256L.15, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 50. Minnesota Statutes 2012, section 256L.15, subdivision 2, is amended to read:

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

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

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

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

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum

46-54%	$4 or 1.1% of family income, whichever is greater
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
~~165-191~~ 165-200%	4.6%
~~192-219%~~	~~5.6%~~
~~220-248%~~	~~6.5%~~
~~249-275%~~	~~7.2%~~

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

Sec. 51. **REPEALER.**

Subdivision 1. **Repeal; certain health care provisions.** Minnesota Statutes 2012, sections 256B.055, subdivisions 3, 5, and 10b; 256B.056, subdivision 5b; and 256B.057, subdivisions 1c and 2, are repealed.

Subd. 2. **Repeal; certain MinnesotaCare provisions.** Minnesota Statutes 2012, sections 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, and 10a; 256L.05, subdivision 3b; 256L.07, subdivisions 5, 8, and 9; 256L.11, subdivision 5; and 256L.17 are repealed effective January 1, 2014.

ARTICLE 2

REFORM 2020; REDESIGNING HOME AND COMMUNITY-BASED SERVICES

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

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

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

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

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

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

38.8 (4) all quarterly assessments must have an assessment reference date (ARD) within
38.9 92 days of the ARD of the previous assessment.

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

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

38.16 (2) a nursing facility level of care determination as provided for under section
38.17 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment
38.18 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
38.19 managed care organization under contract with the Department of Human Services.

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

38.21 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**
38.22 **REPORT AND STUDY REQUIRED.**

38.23 Subdivision 1. **Report requirements.** The commissioners of health and human
38.24 services, with the cooperation of counties and in consultation with stakeholders, including
38.25 persons who need or are using long-term care services and supports, lead agencies,
38.26 regional entities, senior, disability, and mental health organization representatives, service
38.27 providers, and community members shall prepare a report to the legislature by August 15,
38.28 2013, and biennially thereafter, regarding the status of the full range of long-term care
38.29 services and supports for the elderly and children and adults with disabilities and mental
38.30 illnesses in Minnesota. The report shall address:

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

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

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

39.1 (i) changes in availability of the range of long-term care services and housing options;
39.2 (ii) access problems, including access to the least restrictive and most integrated
39.3 services and settings, regarding long-term care services; and
39.4 (iii) comparative measures of long-term care services availability, including serving
39.5 people in their home areas near family, and changes over time; and
39.6 (4) recommendations regarding goals for the future of long-term care services and
39.7 supports, policy and fiscal changes, and resource development and transition needs.
39.8 Subd. 2. **Critical access study.** The commissioner shall conduct a onetime study to
39.9 assess local capacity and availability of home and community-based services for older
39.10 adults, people with disabilities, and people with mental illnesses. The study must assess
39.11 critical access at the community level and identify potential strategies to build home and
39.12 community-based service capacity in critical access areas. The report shall be submitted
39.13 to the legislature no later than August 15, 2015.

39.14 Sec. 3. Minnesota Statutes 2012, section 148E.065, subdivision 4a, is amended to read:
39.15 Subd. 4a. **City, county, and state social workers.** (a) Beginning July 1, 2016, the
39.16 licensure of city, county, and state agency social workers is voluntary, except an individual
39.17 who is newly employed by a city or state agency after July 1, 2016, must be licensed
39.18 if the individual who provides social work services, as those services are defined in
39.19 section 148E.010, subdivision 11, paragraph (b), is presented to the public by any title
39.20 incorporating the words "social work" or "social worker."
39.21 (b) City, county, and state agencies employing social workers and staff who are
39.22 designated to perform mandated duties under sections 256.975, subdivisions 7 to 7c and
39.23 256.01, subdivision 24, are not required to employ licensed social workers.

39.24 Sec. 4. Minnesota Statutes 2012, section 256.01, subdivision 2, is amended to read:
39.25 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision
39.26 2, the commissioner of human services shall carry out the specific duties in paragraphs (a)
39.27 through ~~(cc)~~ (dd):
39.28 (a) Administer and supervise all forms of public assistance provided for by state law
39.29 and other welfare activities or services as are vested in the commissioner. Administration
39.30 and supervision of human services activities or services includes, but is not limited to,
39.31 assuring timely and accurate distribution of benefits, completeness of service, and quality
39.32 program management. In addition to administering and supervising human services
39.33 activities vested by law in the department, the commissioner shall have the authority to:

40.1 (1) require county agency participation in training and technical assistance programs
40.2 to promote compliance with statutes, rules, federal laws, regulations, and policies
40.3 governing human services;
40.4 (2) monitor, on an ongoing basis, the performance of county agencies in the
40.5 operation and administration of human services, enforce compliance with statutes, rules,
40.6 federal laws, regulations, and policies governing welfare services and promote excellence
40.7 of administration and program operation;
40.8 (3) develop a quality control program or other monitoring program to review county
40.9 performance and accuracy of benefit determinations;
40.10 (4) require county agencies to make an adjustment to the public assistance benefits
40.11 issued to any individual consistent with federal law and regulation and state law and rule
40.12 and to issue or recover benefits as appropriate;
40.13 (5) delay or deny payment of all or part of the state and federal share of benefits and
40.14 administrative reimbursement according to the procedures set forth in section 256.017;
40.15 (6) make contracts with and grants to public and private agencies and organizations,
40.16 both profit and nonprofit, and individuals, using appropriated funds; and
40.17 (7) enter into contractual agreements with federally recognized Indian tribes with
40.18 a reservation in Minnesota to the extent necessary for the tribe to operate a federally
40.19 approved family assistance program or any other program under the supervision of the
40.20 commissioner. The commissioner shall consult with the affected county or counties in
40.21 the contractual agreement negotiations, if the county or counties wish to be included,
40.22 in order to avoid the duplication of county and tribal assistance program services. The
40.23 commissioner may establish necessary accounts for the purposes of receiving and
40.24 disbursing funds as necessary for the operation of the programs.
40.25 (b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law,
40.26 regulation, and policy necessary to county agency administration of the programs.
40.27 (c) Administer and supervise all child welfare activities; promote the enforcement of
40.28 laws protecting disabled, dependent, neglected and delinquent children, and children born
40.29 to mothers who were not married to the children's fathers at the times of the conception
40.30 nor at the births of the children; license and supervise child-caring and child-placing
40.31 agencies and institutions; supervise the care of children in boarding and foster homes or
40.32 in private institutions; and generally perform all functions relating to the field of child
40.33 welfare now vested in the State Board of Control.
40.34 (d) Administer and supervise all noninstitutional service to disabled persons,
40.35 including those who are visually impaired, hearing impaired, or physically impaired
40.36 or otherwise disabled. The commissioner may provide and contract for the care and

41.1 treatment of qualified indigent children in facilities other than those located and available
41.2 at state hospitals when it is not feasible to provide the service in state hospitals.

41.3 (e) Assist and actively cooperate with other departments, agencies and institutions,
41.4 local, state, and federal, by performing services in conformity with the purposes of Laws
41.5 1939, chapter 431.

41.6 (f) Act as the agent of and cooperate with the federal government in matters of
41.7 mutual concern relative to and in conformity with the provisions of Laws 1939, chapter
41.8 431, including the administration of any federal funds granted to the state to aid in the
41.9 performance of any functions of the commissioner as specified in Laws 1939, chapter 431,
41.10 and including the promulgation of rules making uniformly available medical care benefits
41.11 to all recipients of public assistance, at such times as the federal government increases its
41.12 participation in assistance expenditures for medical care to recipients of public assistance,
41.13 the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

41.16 (h) Act as designated guardian of both the estate and the person of all the wards of
41.17 the state of Minnesota, whether by operation of law or by an order of court, without any
41.18 further act or proceeding whatever, except as to persons committed as developmentally
41.19 disabled. For children under the guardianship of the commissioner or a tribe in Minnesota
41.20 recognized by the Secretary of the Interior whose interests would be best served by
41.21 adoptive placement, the commissioner may contract with a licensed child-placing agency
41.22 or a Minnesota tribal social services agency to provide adoption services. A contract
41.23 with a licensed child-placing agency must be designed to supplement existing county
41.24 efforts and may not replace existing county programs or tribal social services, unless the
41.25 replacement is agreed to by the county board and the appropriate exclusive bargaining
41.26 representative, tribal governing body, or the commissioner has evidence that child
41.27 placements of the county continue to be substantially below that of other counties. Funds
41.28 encumbered and obligated under an agreement for a specific child shall remain available
41.29 until the terms of the agreement are fulfilled or the agreement is terminated.

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

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

41.34 (k) Establish county, regional, or statewide schedules of maximum fees and charges
41.35 which may be paid by county agencies for medical, dental, surgical, hospital, nursing and
41.36 nursing home care and medicine and medical supplies under all programs of medical

42.1 care provided by the state and for congregate living care under the income maintenance
42.2 programs.

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

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

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

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

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

42.24 (1) one-half of the total amount of the disallowance shall be borne by the county
42.25 boards responsible for administering the programs. For the medical assistance and the
42.26 AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be
42.27 shared by each county board in the same proportion as that county's expenditures for the
42.28 sanctioned program are to the total of all counties' expenditures for the AFDC program
42.29 formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the
42.30 food stamp program, sanctions shall be shared by each county board, with 50 percent of
42.31 the sanction being distributed to each county in the same proportion as that county's
42.32 administrative costs for food stamps are to the total of all food stamp administrative costs
42.33 for all counties, and 50 percent of the sanctions being distributed to each county in the
42.34 same proportion as that county's value of food stamp benefits issued are to the total of
42.35 all benefits issued for all counties. Each county shall pay its share of the disallowance
42.36 to the state of Minnesota. When a county fails to pay the amount due hereunder, the

43.1 commissioner may deduct the amount from reimbursement otherwise due the county, or
43.2 the attorney general, upon the request of the commissioner, may institute civil action
43.3 to recover the amount due; and

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

43.10 (o) Develop and implement special projects that maximize reimbursements and
43.11 result in the recovery of money to the state. For the purpose of recovering state money,
43.12 the commissioner may enter into contracts with third parties. Any recoveries that result
43.13 from projects or contracts entered into under this paragraph shall be deposited in the
43.14 state treasury and credited to a special account until the balance in the account reaches
43.15 $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be
43.16 transferred and credited to the general fund. All money in the account is appropriated to
43.17 the commissioner for the purposes of this paragraph.

43.18 (p) Have the authority to make direct payments to facilities providing shelter
43.19 to women and their children according to section 256D.05, subdivision 3. Upon
43.20 the written request of a shelter facility that has been denied payments under section
43.21 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make
43.22 a determination within 30 days of the request for review regarding issuance of direct
43.23 payments to the shelter facility. Failure to act within 30 days shall be considered a
43.24 determination not to issue direct payments.

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

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

43.32 (2) the county board shall submit monthly or quarterly reports to the department
43.33 as required by the commissioner. Monthly reports are due no later than 15 working days
43.34 after the end of the month. Quarterly reports are due no later than 30 calendar days after
43.35 the end of the quarter, unless the commissioner determines that the deadline must be
43.36 shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines

44.1 or risking a loss of federal funding. Only reports that are complete, legible, and in the
44.2 required format shall be accepted by the commissioner;

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

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

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

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

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

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

45.1 (s) Be responsible for ensuring the detection, prevention, investigation, and
45.2 resolution of fraudulent activities or behavior by applicants, recipients, and other
45.3 participants in the human services programs administered by the department.
45.4 (t) Require county agencies to identify overpayments, establish claims, and utilize
45.5 all available and cost-beneficial methodologies to collect and recover these overpayments
45.6 in the human services programs administered by the department.
45.7 (u) Have the authority to administer a drug rebate program for drugs purchased
45.8 pursuant to the prescription drug program established under section 256.955 after the
45.9 beneficiary's satisfaction of any deductible established in the program. The commissioner
45.10 shall require a rebate agreement from all manufacturers of covered drugs as defined in
45.11 section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on
45.12 or after July 1, 2002, must include rebates for individuals covered under the prescription
45.13 drug program who are under 65 years of age. For each drug, the amount of the rebate shall
45.14 be equal to the rebate as defined for purposes of the federal rebate program in United
45.15 States Code, title 42, section 1396r-8. The manufacturers must provide full payment
45.16 within 30 days of receipt of the state invoice for the rebate within the terms and conditions
45.17 used for the federal rebate program established pursuant to section 1927 of title XIX of
45.18 the Social Security Act. The manufacturers must provide the commissioner with any
45.19 information necessary to verify the rebate determined per drug. The rebate program shall
45.20 utilize the terms and conditions used for the federal rebate program established pursuant to
45.21 section 1927 of title XIX of the Social Security Act.
45.22 (v) Have the authority to administer the federal drug rebate program for drugs
45.23 purchased under the medical assistance program as allowed by section 1927 of title XIX
45.24 of the Social Security Act and according to the terms and conditions of section 1927.
45.25 Rebates shall be collected for all drugs that have been dispensed or administered in an
45.26 outpatient setting and that are from manufacturers who have signed a rebate agreement
45.27 with the United States Department of Health and Human Services.
45.28 (w) Have the authority to administer a supplemental drug rebate program for drugs
45.29 purchased under the medical assistance program. The commissioner may enter into
45.30 supplemental rebate contracts with pharmaceutical manufacturers and may require prior
45.31 authorization for drugs that are from manufacturers that have not signed a supplemental
45.32 rebate contract. Prior authorization of drugs shall be subject to the provisions of section
45.33 256B.0625, subdivision 13.
45.34 (x) Operate the department's communication systems account established in Laws
45.35 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared
45.36 communication costs necessary for the operation of the programs the commissioner

46.1 supervises. A communications account may also be established for each regional
46.2 treatment center which operates communications systems. Each account must be used
46.3 to manage shared communication costs necessary for the operations of the programs the
46.4 commissioner supervises. The commissioner may distribute the costs of operating and
46.5 maintaining communication systems to participants in a manner that reflects actual usage.
46.6 Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and
46.7 other costs as determined by the commissioner. Nonprofit organizations and state, county,
46.8 and local government agencies involved in the operation of programs the commissioner
46.9 supervises may participate in the use of the department's communications technology and
46.10 share in the cost of operation. The commissioner may accept on behalf of the state any
46.11 gift, bequest, devise or personal property of any kind, or money tendered to the state for
46.12 any lawful purpose pertaining to the communication activities of the department. Any
46.13 money received for this purpose must be deposited in the department's communication
46.14 systems accounts. Money collected by the commissioner for the use of communication
46.15 systems must be deposited in the state communication systems account and is appropriated
46.16 to the commissioner for purposes of this section.

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

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

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

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

47.5 (cc) Have the authority to administer a drug rebate program for drugs purchased for
47.6 persons eligible for general assistance medical care under section 256D.03, subdivision 3.
47.7 For manufacturers that agree to participate in the general assistance medical care rebate
47.8 program, the commissioner shall enter into a rebate agreement for covered drugs as
47.9 defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the
47.10 rebate shall be equal to the rebate as defined for purposes of the federal rebate program in
47.11 United States Code, title 42, section 1396r-8. The manufacturers must provide payment
47.12 within the terms and conditions used for the federal rebate program established under
47.13 section 1927 of title XIX of the Social Security Act. The rebate program shall utilize
47.14 the terms and conditions used for the federal rebate program established under section
47.15 1927 of title XIX of the Social Security Act.

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

47.18 (1) are covered under the medical assistance program as described in section
47.19 256B.0625, subdivisions 13 and 13d; and

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

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

47.27 (dd) Designate the agencies that operate the Senior LinkAge Line under section
47.28 256.975, subdivision 7, and the Disability Linkage Line under subdivision 24 as the state
47.29 of Minnesota Aging and the Disability Resource Centers under United States Code, title
47.30 42, section 3001, the Older Americans Act Amendments of 2006 and incorporate cost
47.31 reimbursement claims from the designated centers into the federal cost reimbursement
47.32 claiming processes of the department according to federal law, rule, and regulations. Any
47.33 reimbursement must be appropriated to the commissioner and all Aging and Disability
47.34 Resource Center designated agencies shall receive payments of grant funding that supports
47.35 the activity and generates the federal financial participation according to Board on Aging
47.36 administrative granting mechanisms.

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

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

(1) deliver information and assistance based on national and state standards;

(2) provide information about state and federal eligibility requirements, benefits, and service options;

(3) provide benefits and options counseling;

(4) make referrals to appropriate support entities;

(5) educate people on their options so they can make well-informed choices and link them to quality profiles;

(6) help support the timely resolution of service access and benefit issues;

(7) inform people of their long-term community services and supports;

(8) provide necessary resources and supports that can lead to employment and increased economic stability of people with disabilities; ~~and~~

(9) serve as the technical assistance and help center for the Web-based tool, Minnesota's Disability Benefits 101.org~~.~~; and

(10) provide preadmission screening for individuals under 60 years of age using the procedures as defined in section 256.975, subdivisions 7a to 7c, and 256B.0911, subdivision 4d.

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

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, shall serve older adults as the designated Aging and Disability Resource Center under United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006 in partnership with the Disability LinkAge Line under section 256.01, subdivision 24, and must be available during business hours through a statewide toll-free number and ~~must also be available through~~ the Internet. The Minnesota Board

49.1 on Aging shall consult with, and when appropriate work through, the area agencies on
49.2 aging to provide and maintain the telephony infrastructure and related support for the
49.3 Aging and Disability Resource Center partners which agree by memorandum to access
49.4 the infrastructure, including the designated providers of the Senior LinkAge Line and the
49.5 Disability Linkage Line.

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

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

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

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

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

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

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

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

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

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

The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

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

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

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

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

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

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

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

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

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

(12) develop referral protocols and processes that will assist certified health care homes and hospitals to identify at-risk older adults and determine when to refer these individuals to the Senior LinkAge Line for long-term care options counseling under this section. The commissioner is directed to work with the commissioner of health to develop protocols that would comply with the health care home designation criteria and protocols available at the time of hospital discharge. The commissioner shall keep a record of the number of people who choose long-term care options counseling as a result of this section.

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

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

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

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

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

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

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

52.1 (i) a qualified independent mental health professional, for persons with a primary or
52.2 secondary diagnosis of a serious mental illness; or
52.3 (ii) a qualified developmental disability professional, for persons with a primary or
52.4 secondary diagnosis of developmental disability. For purposes of this requirement, a
52.5 qualified developmental disability professional must meet the standards for a qualified
52.6 developmental disability professional under Code of Federal Regulations, title 42, section
52.7 483.430.
52.8 (d) The local county mental health authority or the state developmental disability
52.9 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
52.10 nursing facility if the individual does not meet the nursing facility level of care criteria or
52.11 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
52.12 purposes of this section, "specialized services" for a person with developmental disability
52.13 means active treatment as that term is defined under Code of Federal Regulations, title
52.14 42, section 483.440(a)(1).
52.15 (e) In assessing a person's needs, the screener shall:
52.16 (1) use an automated system designated by the commissioner;
52.17 (2) consult with care transitions coordinators or physician; and
52.18 (3) consider the assessment of the individual's physician.
52.19 Other personnel may be included in the level of care determination as deemed
52.20 necessary by the screener.

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

52.22 Sec. 8. Minnesota Statutes 2012, section 256.975, is amended by adding a subdivision
52.23 to read:
52.24 Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal
52.25 screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:
52.26 (1) a person who, having entered an acute care facility from a certified nursing
52.27 facility, is returning to a certified nursing facility; or
52.28 (2) a person transferring from one certified nursing facility in Minnesota to another
52.29 certified nursing facility in Minnesota.
52.30 (b) Persons who are exempt from preadmission screening for purposes of level of
52.31 care determination include:
52.32 (1) persons described in paragraph (a);
52.33 (2) an individual who has a contractual right to have nursing facility care paid for
52.34 indefinitely by the Veterans' Administration;

53.1 (3) an individual enrolled in a demonstration project under section 256B.69,
53.2 subdivision 8, at the time of application to a nursing facility; and
53.3 (4) an individual currently being served under the alternative care program or under
53.4 a home and community-based services waiver authorized under section 1915(c) of the
53.5 federal Social Security Act.
53.6 (c) Persons admitted to a Medicaid-certified nursing facility from the community
53.7 on an emergency basis as described in paragraph (d) or from an acute care facility on a
53.8 nonworking day must be screened the first working day after admission.
53.9 (d) Emergency admission to a nursing facility prior to screening is permitted when
53.10 all of the following conditions are met:
53.11 (1) a person is admitted from the community to a certified nursing or certified
53.12 boarding care facility during Senior LinkAge Line nonworking hours for ages 60 and
53.13 older and Disability Linkage Line nonworking hours for under age 60;
53.14 (2) a physician has determined that delaying admission until preadmission screening
53.15 is completed would adversely affect the person's health and safety;
53.16 (3) there is a recent precipitating event that precludes the client from living safely in
53.17 the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's
53.18 inability to continue to provide care;
53.19 (4) the attending physician has authorized the emergency placement and has
53.20 documented the reason that the emergency placement is recommended; and
53.21 (5) the Senior LinkAge Line or Disability Linkage Line is contacted on the first
53.22 working day following the emergency admission.
53.23 Transfer of a patient from an acute care hospital to a nursing facility is not considered
53.24 an emergency except for a person who has received hospital services in the following
53.25 situations: hospital admission for observation, care in an emergency room without hospital
53.26 admission, or following hospital 24-hour bed care and from whom admission is being
53.27 sought on a nonworking day.
53.28 (e) A nursing facility must provide written information to all persons admitted
53.29 regarding the person's right to request and receive long-term care consultation services as
53.30 defined in section 256B.0911, subdivision 1a. The information must be provided prior to
53.31 the person's discharge from the facility and in a format specified by the commissioner.

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

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

54.1 Subd. 7c. **Screening requirements.** (a) A person may be screened for nursing
54.2 facility admission by telephone or in a face-to-face screening interview. The Senior
54.3 LinkAge Line shall identify each individual's needs using the following categories:
54.4 (1) the person needs no face-to-face long-term care consultation assessment
54.5 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
54.6 managed care organization under contract with the Department of Human Services to
54.7 determine the need for nursing facility level of care based on information obtained from
54.8 other health care professionals;
54.9 (2) the person needs an immediate face-to-face long-term care consultation
54.10 assessment completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county,
54.11 tribe, or managed care organization under contract with the Department of Human
54.12 Services to determine the need for nursing facility level of care and complete activities
54.13 required under subdivision 7a; or
54.14 (3) the person may be exempt from screening requirements as outlined in subdivision
54.15 7b, but will need transitional assistance after admission or in-person follow-along after
54.16 a return home.
54.17 (b) Individuals between the ages of 60 and 64 who are admitted to nursing facilities
54.18 with only a telephone screening must receive a face-to-face assessment from the long-term
54.19 care consultation team member of the county in which the facility is located or from the
54.20 recipient's county case manager within 40 calendar days of admission as described in
54.21 section 256B.0911, subdivision 4d, paragraph (c).
54.22 (c) Persons admitted on a nonemergency basis to a Medicaid-certified nursing
54.23 facility must be screened prior to admission.
54.24 (d) Screenings provided by the Senior LinkAge Line must include processes
54.25 to identify persons who may require transition assistance described in subdivision 7,
54.26 paragraph (b), clause (12), and section 256B.0911, subdivision 3b.

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

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

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

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

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

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

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

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

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

55.17 Subd. 5. **Grant preference.** The commissioner of human services shall give
55.18 preference when awarding grants under this section to areas where nursing facility
55.19 closures have occurred or are occurring or areas with service needs identified by section
55.20 144A.351. The commissioner may award grants to the extent grant funds are available
55.21 and to the extent applications are approved by the commissioner. Denial of approval of an
55.22 application in one year does not preclude submission of an application in a subsequent
55.23 year. The maximum grant amount is limited to $750,000.

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

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

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

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

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

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

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

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

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

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

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

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

57.6 Sec. 18. Minnesota Statutes 2012, section 256B.0911, subdivision 1a, is amended to
57.7 read:
57.8 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:
57.9 (a) Until additional requirements apply under paragraph (b), "long-term care
57.10 consultation services" means:
57.11 (1) intake for and access to assistance in identifying services needed to maintain an
57.12 individual in the most inclusive environment;
57.13 (2) providing recommendations for and referrals to cost-effective community
57.14 services that are available to the individual;
57.15 (3) development of an individual's person-centered community support plan;
57.16 (4) providing information regarding eligibility for Minnesota health care programs;
57.17 (5) face-to-face long-term care consultation assessments, which may be completed
57.18 in a hospital, nursing facility, intermediate care facility for persons with developmental
57.19 disabilities (ICF/DDs), regional treatment centers, or the person's current or planned
57.20 residence;
57.21 ~~(6) federally mandated preadmission screening activities described under~~
57.22 ~~subdivisions 4a and 4b;~~
57.23 ~~(7)~~ (6) determination of home and community-based waiver and other service
57.24 eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level
57.25 of care determination for individuals who need an institutional level of care as determined
57.26 under section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, based on assessment and
57.27 community support plan development, appropriate referrals to obtain necessary diagnostic
57.28 information, and including an eligibility determination for consumer-directed community
57.29 supports;
57.30 ~~(8)~~ (7) providing recommendations for institutional placement when there are no
57.31 cost-effective community services available;
57.32 ~~(9)~~ (8) providing access to assistance to transition people back to community settings
57.33 after institutional admission; and
57.34 ~~(10)~~ (9) providing information about competitive employment, with or without
57.35 supports, for school-age youth and working-age adults and referrals to the Disability

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

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

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

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

(ii) section 256B.0657; or

(iii) consumer support grants under section 256.476;

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

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

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

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

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

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

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

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

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

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

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

59.34 (e) If the person chooses to use community-based services, the person or the person's
59.35 legal representative must be provided with a written community support plan within 40

calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

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

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

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

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

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, and section 256.01, subdivision 24, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and

61.1 mental illness collected during the assessment to the long-term care options counselor
61.2 using forms provided by the commissioner;
61.3 (4) the role of long-term care consultation assessment and support planning in
61.4 eligibility determination for waiver and alternative care programs, and state plan home
61.5 care, case management, and other services as defined in subdivision 1a, paragraphs (a),
61.6 clause (7), and (b);
61.7 (5) information about Minnesota health care programs;
61.8 (6) the person's freedom to accept or reject the recommendations of the team;
61.9 (7) the person's right to confidentiality under the Minnesota Government Data
61.10 Practices Act, chapter 13;
61.11 (8) the certified assessor's decision regarding the person's need for institutional level
61.12 of care as determined under criteria established in section 256B.0911, subdivision ~~4a,~~
61.13 ~~paragraph (d)~~ 4e, and the certified assessor's decision regarding eligibility for all services
61.14 and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b); and
61.15 (9) the person's right to appeal the certified assessor's decision regarding eligibility
61.16 for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and
61.17 (b), and incorporating the decision regarding the need for institutional level of care or the
61.18 lead agency's final decisions regarding public programs eligibility according to section
61.19 256.045, subdivision 3.
61.20 (i) Face-to-face assessment completed as part of eligibility determination for
61.21 the alternative care, elderly waiver, community alternatives for disabled individuals,
61.22 community alternative care, and brain injury waiver programs under sections 256B.0913,
61.23 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60
61.24 calendar days after the date of assessment.
61.25 (j) The effective eligibility start date for programs in paragraph (i) can never be
61.26 prior to the date of assessment. If an assessment was completed more than 60 days
61.27 before the effective waiver or alternative care program eligibility start date, assessment
61.28 and support plan information must be updated in a face-to-face visit and documented in
61.29 the department's Medicaid Management Information System (MMIS). Notwithstanding
61.30 retroactive medical assistance coverage of state plan services, the effective date of
61.31 eligibility for programs included in paragraph (i) cannot be prior to the date the most
61.32 recent updated assessment is completed.

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

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

(b) Individuals under ~~65~~ 60 years of age who are admitted to a Medicaid-certified nursing facility ~~from a hospital~~ must be screened prior to admission ~~as outlined in subdivisions 4a through 4c~~ according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Disability Linkage Line as required under section 256.01, subdivision 24.

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

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

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

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

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

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

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

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

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

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

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

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

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

63.29 Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance
63.30 reimbursement for nursing facilities shall be authorized for a medical assistance recipient
63.31 only if a preadmission screening has been conducted prior to admission or the county has
63.32 authorized an exemption. Medical assistance reimbursement for nursing facilities shall
63.33 not be provided for any recipient who the local screener has determined does not meet the
63.34 level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or,

64.1 if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus
64.2 Budget Reconciliation Act of 1987 completed unless an admission for a recipient with
64.3 mental illness is approved by the local mental health authority or an admission for a
64.4 recipient with developmental disability is approved by the state developmental disability
64.5 authority.

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

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

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

64.15 (1) the person has been determined by a community assessment under section
64.16 256B.0911 to be a person who would require the level of care provided in a nursing
64.17 facility, as determined under section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, but for
64.18 the provision of services under the alternative care program;

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

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

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

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

64.28 (6) except for individuals described in clause (7), the monthly cost of the alternative
64.29 care services funded by the program for this person does not exceed 75 percent of the
64.30 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
64.31 does not prohibit the alternative care client from payment for additional services, but in no
64.32 case may the cost of additional services purchased under this section exceed the difference
64.33 between the client's monthly service limit defined under section 256B.0915, subdivision
64.34 3, and the alternative care program monthly service limit defined in this paragraph. If
64.35 care-related supplies and equipment or environmental modifications and adaptations are or

65.1 will be purchased for an alternative care services recipient, the costs may be prorated on a
65.2 monthly basis for up to 12 consecutive months beginning with the month of purchase.
65.3 If the monthly cost of a recipient's other alternative care services exceeds the monthly
65.4 limit established in this paragraph, the annual cost of the alternative care services shall be
65.5 determined. In this event, the annual cost of alternative care services shall not exceed 12
65.6 times the monthly limit described in this paragraph;

65.7 (7) for individuals assigned a case mix classification A as described under section
65.8 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily
65.9 living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating
65.10 when the dependency score in eating is three or greater as determined by an assessment
65.11 performed under section 256B.0911, the monthly cost of alternative care services funded
65.12 by the program cannot exceed $593 per month for all new participants enrolled in
65.13 the program on or after July 1, 2011. This monthly limit shall be applied to all other
65.14 participants who meet this criteria at reassessment. This monthly limit shall be increased
65.15 annually as described in section 256B.0915, subdivision 3a, paragraph (a). This monthly
65.16 limit does not prohibit the alternative care client from payment for additional services, but
65.17 in no case may the cost of additional services purchased exceed the difference between the
65.18 client's monthly service limit defined in this clause and the limit described in clause (6)
65.19 for case mix classification A; and

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

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

65.23 (i) the appointment of a representative payee;

65.24 (ii) automatic payment from a financial account;

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

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

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

65.32 (b) Alternative care funding under this subdivision is not available for a person who
65.33 is a medical assistance recipient or who would be eligible for medical assistance without a
65.34 spenddown or waiver obligation. A person whose initial application for medical assistance
65.35 and the elderly waiver program is being processed may be served under the alternative care
65.36 program for a period up to 60 days. If the individual is found to be eligible for medical

66.1 assistance, medical assistance must be billed for services payable under the federally
66.2 approved elderly waiver plan and delivered from the date the individual was found eligible
66.3 for the federally approved elderly waiver plan. Notwithstanding this provision, alternative
66.4 care funds may not be used to pay for any service the cost of which: (i) is payable by
66.5 medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to
66.6 pay a medical assistance income spenddown for a person who is eligible to participate in the
66.7 federally approved elderly waiver program under the special income standard provision.

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

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

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

66.20 Subd. 17. **Essential community supports grants.** (a) Notwithstanding subdivisions
66.21 1 to 14, the purpose of the essential community supports grant program is to provide
66.22 targeted services to persons age 65 and older who need essential community support, but
66.23 whose needs do not meet the level of care required for nursing facility placement under
66.24 section 144.0724, subdivision 11.

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

66.28 (1) is age 65 or older;

66.29 (2) is not eligible for medical assistance;

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

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

66.34 (5) has a community support plan; and

67.1 (6) has been determined by a community assessment under section 256B.0911,
67.2 subdivision 3a or 3b, to be a person who would require provision of at least one of the
67.3 following services, as defined in the approved elderly waiver plan, in order to maintain
67.4 their community residence:
67.5 (i) caregiver support;
67.6 (ii) homemaker support;
67.7 (iii) chores; or
67.8 (iv) a personal emergency response device or system.
67.9 (c) The person receiving any of the essential community supports in this subdivision
67.10 must also receive service coordination, not to exceed $600 in a 12-month authorization
67.11 period, as part of their community support plan.
67.12 (d) A person who has been determined to be eligible for an essential community
67.13 supports grant must be reassessed at least annually and continue to meet the criteria in
67.14 paragraph (b) to remain eligible for an essential community supports grant.
67.15 (e) The commissioner is authorized to use federal matching funds for essential
67.16 community supports as necessary and to meet demand for essential community supports
67.17 grants as outlined in paragraphs (f) and (g), and that amount of federal funds is
67.18 appropriated to the commissioner for this purpose.
67.19 (f) Upon federal approval and following a reasonable implementation period
67.20 determined by the commissioner, essential community supports are available to an
67.21 individual who:
67.22 (1) is receiving nursing facility services or home and community-based long-term
67.23 services and supports under section 256B.0915 or 256B.49 on the effective date of
67.24 implementation of the revised nursing facility level of care under section 144.0724,
67.25 subdivision 11;
67.26 (2) meets one of the following criteria:
67.27 (i) due to the implementation of the revised nursing facility level of care, loses
67.28 eligibility for continuing medical assistance payment of nursing facility services at the
67.29 first reassessment under section 144.0724, subdivision 11, paragraph (b), that occurs on or
67.30 after the effective date of the revised nursing facility level of care criteria under section
67.31 144.0724, subdivision 11; or
67.32 (ii) due to the implementation of the revised nursing facility level of care, loses
67.33 eligibility for continuing medical assistance payment of home and community-based
67.34 long-term services and supports under section 256B.0915 or 256B.49 at the first
67.35 reassessment required under those sections that occurs on or after the effective date of

68.1 implementation of the revised nursing facility level of care under section 144.0724,
68.2 subdivision 11;
68.3 (3) is not eligible for personal care attendant services; and
68.4 (4) has an assessed need for one or more of the supportive services offered under
68.5 essential community supports.
68.6 Individuals eligible under this paragraph includes individuals who continue to be
68.7 eligible for medical assistance state plan benefits and those who are not or are no longer
68.8 financially eligible for medical assistance.
68.9 (g) Upon federal approval and following a reasonable implementation period
68.10 determined by the commissioner, the services available through essential community
68.11 supports include the services and grants provided in paragraphs (b) and (c), home-delivered
68.12 meals, and community living assistance as defined by the commissioner. These services
68.13 are available to all eligible recipients including those outlined in paragraphs (b) and (f).
68.14 Recipients are eligible if they have a need for any of these services and meet all other
68.15 eligibility criteria.

68.16 Sec. 25. Minnesota Statutes 2012, section 256B.0915, subdivision 3a, is amended to
68.17 read:
68.18 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
68.19 waivered services to an individual elderly waiver client except for individuals described in
68.20 ~~paragraph~~ paragraphs (b) and (d) shall be the weighted average monthly nursing facility
68.21 rate of the case mix resident class to which the elderly waiver client would be assigned
68.22 under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance
68.23 needs allowance as described in subdivision 1d, paragraph (a), until the first day of the
68.24 state fiscal year in which the resident assessment system as described in section 256B.438
68.25 for nursing home rate determination is implemented. Effective on the first day of the state
68.26 fiscal year in which the resident assessment system as described in section 256B.438 for
68.27 nursing home rate determination is implemented and the first day of each subsequent state
68.28 fiscal year, the monthly limit for the cost of waivered services to an individual elderly
68.29 waiver client shall be the rate of the case mix resident class to which the waiver client
68.30 would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on
68.31 the last day of the previous state fiscal year, adjusted by any legislatively adopted home
68.32 and community-based services percentage rate adjustment.
68.33 (b) The monthly limit for the cost of waivered services to an individual elderly
68.34 waiver client assigned to a case mix classification A under paragraph (a) with:
68.35 (1) no dependencies in activities of daily living; or

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

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

69.8 (c) If extended medical supplies and equipment or environmental modifications are
69.9 or will be purchased for an elderly waiver client, the costs may be prorated for up to
69.10 12 consecutive months beginning with the month of purchase. If the monthly cost of a
69.11 recipient's waivered services exceeds the monthly limit established in paragraph (a) or
69.12 (b), the annual cost of all waivered services shall be determined. In this event, the annual
69.13 cost of all waivered services shall not exceed 12 times the monthly limit of waivered
69.14 services as described in paragraph (a) or (b).

69.15 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including
69.16 any necessary home care services described in section 256B.0651, subdivision 2, for
69.17 individuals who meet the criteria as ventilator-dependent given in section 256B.0651,
69.18 subdivision 1, paragraph (g), shall be the average of the monthly medical assistance
69.19 amount established for home care services as described in section 256B.0652, subdivision
69.20 7, and the annual average contracted amount established by the commissioner for nursing
69.21 facility services for ventilator-dependent individuals. This monthly limit shall be increased
69.22 annually as described in paragraph (a).

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

69.25 Subd. 3j. **Individual community living support.** Upon federal approval, there
69.26 is established a new service called individual community living support (ICLS) that is
69.27 available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor
69.28 have any interest in the recipient's housing. ICLS must be delivered in a single-family
69.29 home or apartment where the service recipient or their family owns or rents, as
69.30 demonstrated by a lease agreement, and maintains control over the individual unit. Case
69.31 managers or care coordinators must develop individual ICLS plans in consultation with
69.32 the client using a tool developed by the commissioner. The commissioner shall establish
69.33 payment rates and mechanisms to align payments with the type and amount of service
69.34 provided, assure statewide uniformity for payment rates, and assure cost-effectiveness.
69.35 Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and

70.1 Human Services to avoid conflict with provider regulatory standards pursuant to section
70.2 144A.43 and chapter 245D.

70.3 Sec. 27. Minnesota Statutes 2012, section 256B.0915, subdivision 5, is amended to read:
70.4 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
70.5 shall receive an initial assessment of strengths, informal supports, and need for services
70.6 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
70.7 client served under the elderly waiver must be conducted at least every 12 months and at
70.8 other times when the case manager determines that there has been significant change in
70.9 the client's functioning. This may include instances where the client is discharged from
70.10 the hospital. There must be a determination that the client requires nursing facility level
70.11 of care as defined in section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, at initial and
70.12 subsequent assessments to initiate and maintain participation in the waiver program.
70.13 (b) Regardless of other assessments identified in section 144.0724, subdivision
70.14 4, as appropriate to determine nursing facility level of care for purposes of medical
70.15 assistance payment for nursing facility services, only face-to-face assessments conducted
70.16 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
70.17 level of care determination will be accepted for purposes of initial and ongoing access to
70.18 waiver service payment.

70.19 Sec. 28. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
70.20 subdivision to read:
70.21 Subd. 1a. **Home and community-based services for older adults.** (a) The purpose
70.22 of projects selected by the commissioner of human services under this section is to
70.23 make strategic changes in the long-term services and supports system for older adults
70.24 including statewide capacity for local service development and technical assistance, and
70.25 statewide availability of home and community-based services for older adult services,
70.26 caregiver support and respite care services, and other supports in the state of Minnesota.
70.27 These projects are intended to create incentives for new and expanded home and
70.28 community-based services in Minnesota in order to:
70.29 (1) reach older adults early in the progression of their need for long-term services
70.30 and supports, providing them with low-cost, high-impact services that will prevent or
70.31 delay the use of more costly services;
70.32 (2) support older adults to live in the most integrated, least restrictive community
70.33 setting;
70.34 (3) support the informal caregivers of older adults;

71.1 (4) develop and implement strategies to integrate long-term services and supports
71.2 with health care services, in order to improve the quality of care and enhance the quality
71.3 of life of older adults and their informal caregivers;
71.4 (5) ensure cost-effective use of financial and human resources;
71.5 (6) build community-based approaches and community commitment to delivering
71.6 long-term services and supports for older adults in their own homes;
71.7 (7) achieve a broad awareness and use of lower-cost in-home services as an
71.8 alternative to nursing homes and other residential services;
71.9 (8) strengthen and develop additional home and community-based services and
71.10 alternatives to nursing homes and other residential services; and
71.11 (9) strengthen programs that use volunteers.
71.12 (b) The services provided by these projects are available to older adults who are
71.13 eligible for medical assistance and the elderly waiver under section 256B.0915, the
71.14 alternative care program under section 256B.0913, or essential community supports grant
71.15 under subdivision 14, paragraph (b), and to persons who have their own funds to pay for
71.16 services.

71.17 Sec. 29. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
71.18 subdivision to read:
71.19 Subd. 1b. **Definitions.** (a) For purposes of this section, the following terms have
71.20 the meanings given.
71.21 (b) "Community" means a town; township; city; or targeted neighborhood within a
71.22 city; or a consortium of towns, townships, cities, or specific neighborhoods within a city.
71.23 (c) "Core home and community-based services provider" means a Faith in Action,
71.24 Living at Home Block Nurse, Congregational Nurse, or similar community-based
71.25 program governed by a board, the majority of whose members reside within the program's
71.26 service area, that organizes and uses volunteers and paid staff to deliver nonmedical
71.27 services intended to assist older adults to identify and manage risks and to maintain their
71.28 community living and integration in the community.
71.29 (d) "Eldercare development partnership" means a team of representatives of county
71.30 social service and public health agencies, the area agency on aging, local nursing home
71.31 providers, local home care providers, and other appropriate home and community-based
71.32 providers in the area agency's planning and service area.
71.33 (e) "Long-term services and supports" means any service available under the
71.34 elderly waiver program or alternative care grant programs; nursing facility services;
71.35 transportation services; caregiver support and respite care services; and other home and

72.1 community-based services identified as necessary either to maintain lifestyle choices for
72.2 older adults or to support them to remain in their own home.
72.3 (f) "Older adult" refers to an individual who is 65 years of age or older.

72.4 Sec. 30. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
72.5 subdivision to read:
72.6 Subd. 1c. **Eldercare development partnerships.** The commissioner of human
72.7 services shall select and contract with eldercare development partnerships sufficient to
72.8 provide statewide availability of service development and technical assistance using a
72.9 request for proposals process. Eldercare development partnerships shall:
72.10 (1) develop a local long-term services and supports strategy consistent with state
72.11 goals and objectives;
72.12 (2) identify and use existing local skills, knowledge and relationships, and build
72.13 on these assets;
72.14 (3) coordinate planning for funds to provide services to older adults, including funds
72.15 received under Title III of the Older Americans Act, Title XX of the Social Security Act,
72.16 and the Local Public Health Act;
72.17 (4) target service development and technical assistance where nursing facility
72.18 closures have occurred or are occurring or in areas where service needs have been
72.19 identified through activities under section 144A.351;
72.20 (5) provide sufficient staff for development and technical support in its designated
72.21 area; and
72.22 (6) designate a single public or nonprofit member of the eldercare development
72.23 partnerships to apply grant funding and manage the project.

72.24 Sec. 31. Minnesota Statutes 2012, section 256B.0917, subdivision 6, is amended to read:
72.25 Subd. 6. **Caregiver support and respite care projects.** (a) The commissioner
72.26 shall establish ~~up to 36~~ projects to expand the ~~respite care network in the state and to~~
72.27 ~~support caregivers in their responsibilities for care. The purpose of each project shall~~
72.28 ~~be to~~ availability of caregiver support and respite care services for family and other
72.29 caregivers. The commissioner shall use a request for proposals to select nonprofit entities
72.30 to administer the projects. Projects shall:
72.31 (1) establish a local coordinated network of volunteer and paid respite workers;
72.32 (2) coordinate assignment of respite ~~workers~~ care services to ~~clients and care~~
72.33 ~~receivers and assure the health and safety of the client; and~~ caregivers of older adults;

73.1 (3) provide training for caregivers and ensure that support groups are available
73.2 in the community.
73.3 (3) assure the health and safety of the older adults;
73.4 (4) identify at-risk caregivers;
73.5 (5) provide information, education, and training for caregivers in the designated
73.6 community; and
73.7 (6) demonstrate the need in the proposed service area particularly where nursing
73.8 facility closures have occurred or are occurring or areas with service needs identified
73.9 by section 144A.351. Preference must be given for projects that reach underserved
73.10 populations.
73.11 (b) The caregiver support and respite care funds shall be available to the four to six
73.12 local long-term care strategy projects designated in subdivisions 1 to 5.
73.13 (c) The commissioner shall publish a notice in the State Register to solicit proposals
73.14 from public or private nonprofit agencies for the projects not included in the four to six
73.15 local long-term care strategy projects defined in subdivision 2. A county agency may,
73.16 alone or in combination with other county agencies, apply for caregiver support and
73.17 respite care project funds. A public or nonprofit agency within a designated SAIL project
73.18 area may apply for project funds if the agency has a letter of agreement with the county
73.19 or counties in which services will be developed, stating the intention of the county or
73.20 counties to coordinate their activities with the agency requesting a grant.
73.21 (d) The commissioner shall select grantees based on the following criteria (b)
73.22 Projects must clearly describe:
73.23 (1) the ability of the proposal to demonstrate need in the area served, as evidenced
73.24 by a community needs assessment or other demographic data;
73.25 (2) the ability of the proposal to clearly describe how the project (1) how they will
73.26 achieve the their purpose defined in paragraph (b);
73.27 (3) the ability of the proposal to reach underserved populations;
73.28 (4) the ability of the proposal to demonstrate community commitment to the project,
73.29 as evidenced by letters of support and cooperation as well as formation of a community
73.30 task force;
73.31 (5) the ability of the proposal to clearly describe (2) the process for recruiting,
73.32 training, and retraining volunteers; and
73.33 (6) the inclusion in the proposal of the (3) their plan to promote the project in the
73.34 designated community, including outreach to persons needing the services.
73.35 (e) (c) Funds for all projects under this subdivision may be used to:

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

(2) recruit and train volunteer providers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 13. **Community service grants.** The commissioner shall award contracts for grants to public and private nonprofit agencies to establish services that strengthen

75.1 a community's ability to provide a system of home and community-based services
75.2 for elderly persons. The commissioner shall use a request for proposal process. The
75.3 commissioner shall give preference when awarding grants under this section to areas
75.4 where nursing facility closures have occurred or are occurring or to areas with service
75.5 needs identified under section 144A.351. ~~The commissioner shall consider grants for:~~
75.6 ~~(1) caregiver support and respite care projects under subdivision 6;~~
75.7 ~~(2) the living-at-home/block nurse grant under subdivisions 7 to 10; and~~
75.8 ~~(3) services identified as needed for community transition.~~

75.9 Sec. 34. Minnesota Statutes 2012, section 256B.092, is amended by adding a
75.10 subdivision to read:
75.11 Subd. 14. **Reduce avoidable behavioral crisis emergency room, psychiatric**
75.12 **inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving
75.13 home and community-based services authorized under this section who have had two
75.14 or more admissions within a calendar year to an emergency room, psychiatric unit,
75.15 or institution must receive consultation from a mental health professional as defined in
75.16 section 245.462, subdivision 18, or a behavioral professional as defined in the home and
75.17 community-based services state plan within 30 days of discharge. The mental health
75.18 professional or behavioral professional must:
75.19 (1) conduct a functional assessment of the crisis incident as defined in section
75.20 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
75.21 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
75.22 future avoidable hospitalizations due to a behavioral crisis;
75.23 (2) use the results of the functional assessment to amend the coordinated service and
75.24 support plan set forth in section 245D.02, subdivision 4b, to address the potential need
75.25 for additional staff training, increased staffing, access to crisis mobility services, mental
75.26 health services, use of technology, and crisis stabilization services in section 256B.0624,
75.27 subdivision 7; and
75.28 (3) identify the need for additional consultation, testing, and mental health crisis
75.29 intervention team services as defined in section 245D.02, subdivision 20, psychotropic
75.30 medication use and monitoring under section 245D.051, as well as the frequency and
75.31 duration of ongoing consultation.
75.32 (b) For the purposes of this subdivision, "institution" includes, but is not limited to,
75.33 the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

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

76.1 Subdivision 1. **Development and implementation of quality profiles.** (a) The
76.2 commissioner of human services, in cooperation with the commissioner of health,
76.3 shall develop and implement a quality profile system profiles for nursing facilities and,
76.4 beginning not later than July 1, 2004 2014, other providers of long-term care services,
76.5 except when the quality profile system would duplicate requirements under section
76.6 256B.5011, 256B.5012, or 256B.5013. The system quality profiles must be developed
76.7 and implemented to the extent possible without the collection of significant amounts of
76.8 new data. To the extent possible, the system using existing data sets maintained by the
76.9 commissioners of health and human services to the extent possible. The profiles must
76.10 incorporate or be coordinated with information on quality maintained by area agencies on
76.11 aging, long-term care trade associations, the ombudsman offices, counties, tribes, health
76.12 plans, and other entities and the long-term care database maintained under section 256.975,
76.13 subdivision 7. The system profiles must be designed to provide information on quality to:
76.14 (1) consumers and their families to facilitate informed choices of service providers;
76.15 (2) providers to enable them to measure the results of their quality improvement
76.16 efforts and compare quality achievements with other service providers; and
76.17 (3) public and private purchasers of long-term care services to enable them to
76.18 purchase high-quality care.
76.19 (b) The system profiles must be developed in consultation with the long-term care
76.20 task force, area agencies on aging, and representatives of consumers, providers, and labor
76.21 unions. Within the limits of available appropriations, the commissioners may employ
76.22 consultants to assist with this project.

76.23 Sec. 36. Minnesota Statutes 2012, section 256B.439, subdivision 2, is amended to read:
76.24 Subd. 2. **Quality measurement tools.** The commissioners shall identify and apply
76.25 existing quality measurement tools to:
76.26 (1) emphasize quality of care and its relationship to quality of life; and
76.27 (2) address the needs of various users of long-term care services, including, but not
76.28 limited to, short-stay residents, persons with behavioral problems, persons with dementia,
76.29 and persons who are members of minority groups.
76.30 The tools must be identified and applied, to the extent possible, without requiring
76.31 providers to supply information beyond current state and federal requirements.

76.32 Sec. 37. Minnesota Statutes 2012, section 256B.439, subdivision 3, is amended to read:
76.33 Subd. 3. **Consumer surveys of nursing facilities residents.** Following
76.34 identification of the quality measurement tool, the commissioners shall conduct surveys

77.1 of long-term care service consumers of nursing facilities to develop quality profiles
77.2 of providers. To the extent possible, surveys must be conducted face-to-face by state
77.3 employees or contractors. At the discretion of the commissioners, surveys may be
77.4 conducted by telephone or by provider staff. Surveys must be conducted periodically to
77.5 update quality profiles of individual ~~service~~ nursing facilities providers.

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

77.8 Subd. 3a. **Home and community-based services report card in cooperation with**
77.9 **the commissioner of health.** The profiles developed for home and community-based
77.10 services providers under this section shall be incorporated into a report card and
77.11 maintained by the Minnesota Board on Aging pursuant to section 256.975, subdivision
77.12 7, paragraph (b), clause (2), as data becomes available. The commissioner, in
77.13 cooperation with the commissioner of health, shall use consumer choice, quality of life,
77.14 care approaches, and cost or flexible purchasing categories to organize the consumer
77.15 information in the profiles. The final categories used shall include consumer input and
77.16 survey data to the extent that is available through the state agencies. The commissioner
77.17 shall develop and disseminate the qualify profiles for a limited number of provider types
77.18 initially, and develop quality profiles for additional provider types as measurement tools
77.19 are developed and data becomes available. This includes providers of services to older
77.20 adults and people with disabilities, regardless of payor source.

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

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

77.29 Sec. 40. Minnesota Statutes 2012, section 256B.49, subdivision 12, is amended to read:

77.30 Subd. 12. **Informed choice.** Persons who are determined likely to require the level
77.31 of care provided in a nursing facility as determined under section 256B.0911, subdivision
77.32 4e, or a hospital shall be informed of the home and community-based support alternatives
77.33 to the provision of inpatient hospital services or nursing facility services. Each person

must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 41. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

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

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

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

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

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

79.1 functioning. Counties, case managers, and service providers are responsible for
79.2 conducting these reassessments and shall complete the reassessments out of existing funds.

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

79.5 Subd. 25. **Reduce avoidable behavioral crisis emergency room, psychiatric**
79.6 **inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving
79.7 home and community-based services authorized under this section who have two or more
79.8 admissions within a calendar year to an emergency room, psychiatric unit, or institution
79.9 must receive consultation from a mental health professional as defined in section 245.462,
79.10 subdivision 18, or a behavioral professional as defined in the home and community-based
79.11 services state plan within 30 days of discharge. The mental health professional or
79.12 behavioral professional must:

79.13 (1) conduct a functional assessment of the crisis incident as defined in section
79.14 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
79.15 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
79.16 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

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

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

79.32 (b) CFSS is a participant-controlled method of selecting and providing services
79.33 and supports that allows the participant maximum control of the services and supports.
79.34 Participants may choose the degree to which they direct and manage their supports by

80.1 choosing to have a significant and meaningful role in the management of services and
80.2 supports including by directly employing support workers with the necessary supports
80.3 to perform that function.

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

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

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

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

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

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

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

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

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

81.1 and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined
81.2 by the participant to meet the assessed needs, using a person-centered planning process.
81.3 (h) "Critical activities of daily living" means transferring, mobility, eating, and
81.4 toileting.
81.5 (i) "Dependency" in activities of daily living means a person requires assistance to
81.6 begin and complete one or more of the activities of daily living.
81.7 (j) "Financial management services contractor or vendor" means a qualified
81.8 organization having a written contract with the department to provide services necessary
81.9 to use the flexible spending model under subdivision 13, that include but are not limited
81.10 to: participant education and technical assistance; CFSS service delivery planning and
81.11 budgeting; billing, making payments, and monitoring of spending; and assisting the
81.12 participant in fulfilling employer-related requirements in accordance with Section 3504 of
81.13 the IRS code and the IRS Revenue Procedure 70-6.
81.14 (k) "Flexible spending model" means a service delivery method of CFSS that uses
81.15 an individualized CFSS service delivery plan and service budget and assistance from the
81.16 financial management services contractor to facilitate participant employment of support
81.17 workers and the acquisition of supports and goods.
81.18 (l) "Health-related procedures and tasks" means procedures and tasks related to
81.19 the specific needs of an individual that can be delegated or assigned by a state-licensed
81.20 healthcare or behavioral health professional and performed by a support worker.
81.21 (m) "Instrumental activities of daily living" means activities related to living
81.22 independently in the community, including but not limited to: meal planning, preparation,
81.23 and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning;
81.24 assistance with medications; managing money; communicating needs, preferences, and
81.25 activities; arranging supports; and assistance with traveling around and participating
81.26 in the community.
81.27 (n) "Legal representative" means parent of a minor, a court-appointed guardian, or
81.28 another representative with legal authority to make decisions about services and supports
81.29 for the participant. Other representatives with legal authority to make decisions include
81.30 but are not limited to a health care agent or an attorney-in-fact authorized through a health
81.31 care directive or power of attorney.
81.32 (o) "Medication assistance" means providing verbal or visual reminders to take
81.33 regularly scheduled medication and includes any of the following supports:
81.34 (1) under the direction of the participant or the participant's representative, bringing
81.35 medications to the participant including medications given through a nebulizer, opening a
81.36 container of previously set up medications, emptying the container into the participant's

82.1 hand, opening and giving the medication in the original container to the participant, or
82.2 bringing to the participant liquids or food to accompany the medication;
82.3 (2) organizing medications as directed by the participant or the participant's
82.4 representative; and
82.5 (3) providing verbal or visual reminders to perform regularly scheduled medications.
82.6 (p) "Participant's representative" means a parent, family member, advocate, or
82.7 other adult authorized by the participant to serve as a representative in connection with
82.8 the provision of CFSS. This authorization must be in writing or by another method
82.9 that clearly indicates the participant's free choice. The participant's representative must
82.10 have no financial interest in the provision of any services included in the participant's
82.11 service delivery plan and must be capable of providing the support necessary to assist
82.12 the participant in the use of CFSS. If through the assessment process described in
82.13 subdivision 5 a participant is determined to be in need of a participant's representative, one
82.14 must be selected. If the participant is unable to assist in the selection of a participant's
82.15 representative, the legal representative shall appoint one. Two persons may be designated
82.16 as a participant's representative for reasons such as divided households and court-ordered
82.17 custodies. Duties of a participant's representatives may include:
82.18 (1) being available while care is provided in a method agreed upon by the participant
82.19 or the participant's legal representative and documented in the participant's CFSS service
82.20 delivery plan;
82.21 (2) monitoring CFSS services to ensure the participant's CFSS service delivery
82.22 plan is being followed; and
82.23 (3) reviewing and signing CFSS time sheets after services are provided to provide
82.24 verification of the CFSS services.
82.25 (q) "Person-centered planning process" means a process that is driven by the
82.26 participant for discovering and planning services and supports that ensures the participant
82.27 makes informed choices and decisions. The person-centered planning process must:
82.28 (1) include people chosen by the participant;
82.29 (2) provide necessary information and support to ensure that the participant directs
82.30 the process to the maximum extent possible, and is enabled to make informed choices
82.31 and decisions;
82.32 (3) be timely and occur at time and locations of convenience to the participant;
82.33 (4) reflect cultural considerations of the participant;
82.34 (5) include strategies for solving conflict or disagreement within the process,
82.35 including clear conflict-of-interest guidelines for all planning;

83.1 (6) offers choices to the participant regarding the services and supports they receive
83.2 and from whom;
83.3 (7) include a method for the participant to request updates to the plan; and
83.4 (8) record the alternative home and community-based settings that were considered
83.5 by the participant.
83.6 (r) "Shared services" means the provision of CFSS services by the same CFSS
83.7 support worker to two or three participants who voluntarily enter into an agreement to
83.8 receive services at the same time and in the same setting by the same provider.
83.9 (s) "Support specialist" means a professional with the skills and ability to assist the
83.10 participant using either the agency provider model under subdivision 11 or the flexible
83.11 spending model under subdivision 13, in services including, but not limited to assistance
83.12 regarding:
83.13 (1) the development, implementation, and evaluation of the CFSS service delivery
83.14 plan under subdivision 6;
83.15 (2) recruitment, training, or supervision, including supervision of health-related
83.16 tasks or behavioral supports appropriately delegated by a health care professional, and
83.17 evaluation of support workers; and
83.18 (3) facilitating the use of informal and community supports, goods, or resources.
83.19 (t) "Support worker" means an employee of the agency provider or of the participant
83.20 who has direct contact with the participant and provides services as specified within the
83.21 participant's service delivery plan.
83.22 (u) "Wages and benefits" means the hourly wages and salaries, the employer's
83.23 share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers'
83.24 compensation, mileage reimbursement, health and dental insurance, life insurance,
83.25 disability insurance, long-term care insurance, uniform allowance, contributions to
83.26 employee retirement accounts, or other forms of employee compensation and benefits.
83.27 Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the
83.28 following:
83.29 (1) is a recipient of medical assistance as determined under section 256B.055,
83.30 256B.056, or 256B.057, subdivisions 5 and 9;
83.31 (2) is a recipient of the alternative care program under section 256B.0913;
83.32 (3) is a waiver recipient as defined under section 256B.0915, 256B.092, 256B.093,
83.33 or 256B.49; or
83.34 (4) has medical services identified in a participant's individualized education
83.35 program and is eligible for services as determined in section 256B.0625, subdivision 26.

84.1 (b) In addition to meeting the eligibility criteria in paragraph (a), a person must also
84.2 meet all of the following:
84.3 (1) require assistance and be determined dependent in one activity of daily living or
84.4 Level I behavior based on assessment under section 256B.0911;
84.5 (2) is not a recipient under the family support grant under section 252.32;
84.6 (3) lives in the person's own apartment or home including a family foster care setting
84.7 licensed under chapter 245A, but not in corporate foster care under chapter 245A; or a
84.8 noncertified boarding care or boarding and lodging establishments under chapter 157;
84.9 unless transitioning into the community from an institution; and
84.10 (4) has not been excluded or disenrolled from the flexible spending model.
84.11 (c) The commissioner shall disenroll or exclude participants from the flexible
84.12 spending model and transfer them to the agency-provider model under the following
84.13 circumstances that include but are not limited to:
84.14 (1) when a participant has been restricted by the Minnesota restricted recipient
84.15 program, the participant may be excluded for a specified time period;
84.16 (2) when a participant exits the flexible spending service delivery model during the
84.17 participant's service plan year. Upon transfer, the participant shall not access the flexible
84.18 spending model for the remainder of that service plan year; or
84.19 (3) when the department determines that the participant or participant's representative
84.20 or legal representative cannot manage participant responsibilities under the service
84.21 delivery model. The commissioner must develop policies for determining if a participant
84.22 is unable to manage responsibilities under a service model.
84.23 (d) A participant may appeal in writing to the department to contest the department's
84.24 decision under paragraph (c), clause (3), to remove or exclude the participant from the
84.25 flexible spending model.
84.26 Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not
84.27 restrict access to other medically necessary care and services furnished under the state
84.28 plan medical assistance benefit or other services available through alternative care.
84.29 Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:
84.30 (1) be conducted by a certified assessor according to the criteria established in
84.31 section 256B.0911;
84.32 (2) be conducted face-to-face, initially and at least annually thereafter, or when there
84.33 is a significant change in the participant's condition or a change in the need for services
84.34 and supports; and
84.35 (3) be completed using the format established by the commissioner.

85.1 (b) A participant who is residing in a facility may be assessed and choose CFSS for
85.2 the purpose of using CFSS to return to the community as described in subdivisions 3
85.3 and 7, paragraph (a), clause (5).
85.4 (c) The results of the assessment and any recommendations and authorizations for
85.5 CFSS must be determined and communicated in writing by the lead agency's certified
85.6 assessor as defined in section 256B.0911 to the participant and the agency-provider or
85.7 financial management services provider chosen by the participant within 40 calendar days
85.8 and must include the participant's right to appeal under section 256.045.
85.9 Subd. 6. **Community first services and support service delivery plan.** (a) The
85.10 CFSS service delivery plan must be developed, implemented, and evaluated through a
85.11 person-centered planning process by the participant, or the participant's representative
85.12 or legal representative who may be assisted by a support specialist. The CFSS service
85.13 delivery plan must reflect the services and supports that are important to the participant
85.14 and for the participant to meet the needs assessed by the certified assessor and identified
85.15 in the community support plan under section 256B.0911 or the coordinated services and
85.16 support plan identified in section 256B.0915, subdivision 6, if applicable. The CFSS
85.17 service delivery plan must be reviewed by the participant and the agency-provider or
85.18 financial management services contractor at least annually upon reassessment, or when
85.19 there is a significant change in the participant's condition, or a change in the need for
85.20 services and supports.
85.21 (b) The commissioner shall establish the format and criteria for the CFSS service
85.22 delivery plan.
85.23 (c) The CFSS service delivery plan must be person-centered and:
85.24 (1) specify the agency-provider or financial management services contractor selected
85.25 by the participant;
85.26 (2) reflect the setting in which the participant resides that is chosen by the participant;
85.27 (3) reflect the participant's strengths and preferences;
85.28 (4) include the means to address the clinical and support needs as identified through
85.29 an assessment of functional needs;
85.30 (5) include individually identified goals and desired outcomes;
85.31 (6) reflect the services and supports, paid and unpaid, that will assist the participant
85.32 to achieve identified goals, and the providers of those services and supports, including
85.33 natural supports;
85.34 (7) identify the amount and frequency of face-to-face supports and amount and
85.35 frequency of remote supports and technology that will be used;

86.1 (8) identify risk factors and measures in place to minimize them, including
86.2 individualized backup plans;
86.3 (9) be understandable to the participant and the individuals providing support;
86.4 (10) identify the individual or entity responsible for monitoring the plan;
86.5 (11) be finalized and agreed to in writing by the participant and signed by all
86.6 individuals and providers responsible for its implementation;
86.7 (12) be distributed to the participant and other people involved in the plan; and
86.8 (13) prevent the provision of unnecessary or inappropriate care.
86.9 (d) The total units of agency-provider services or the budget allocation amount for
86.10 the flexible spending model include both annual totals and a monthly average amount
86.11 that cover the number of months of the service authorization. The amount used each
86.12 month may vary, but additional funds must not be provided above the annual service
86.13 authorization amount unless a change in condition is assessed and authorized by the
86.14 certified assessor and documented in the community support plan, coordinated services
86.15 and supports plan, and service delivery plan.
86.16 Subd. 7. **Community first services and supports; covered services.** Services
86.17 and supports covered under CFSS include:
86.18 (1) assistance to accomplish activities of daily living (ADLs), instrumental activities
86.19 of daily living (IADLs), and health-related procedures and tasks through hands-on
86.20 assistance to complete the task or supervision and cueing to complete the task;
86.21 (2) assistance to acquire, maintain, or enhance the skills necessary for the participant
86.22 to accomplish activities of daily living, instrumental activities of daily living, or
86.23 health-related tasks;
86.24 (3) expenditures for items, services, supports, environmental modifications, or
86.25 goods, including assistive technology. These expenditures must:
86.26 (i) relate to a need identified in a participant's CFSS service delivery plan;
86.27 (ii) increase independence or substitute for human assistance to the extent that
86.28 expenditures would otherwise be made for human assistance for the participant's assessed
86.29 needs; and
86.30 (iii) fit within the annual limit of the participant's approved service allocation
86.31 or budget;
86.32 (4) observation and redirection for episodes where there is a need for redirection
86.33 due to participant behaviors or intervention needed due to a participant's symptoms. An
86.34 assessment of behaviors must meet the criteria in this clause. A recipient qualifies as
86.35 having a need for assistance due to behaviors if the recipient's behavior requires assistance
86.36 at least four times per week and shows one or more of the following behaviors:

87.1 (i) physical aggression towards self or others, or destruction of property that requires
87.2 the immediate response of another person;
87.3 (ii) increased vulnerability due to cognitive deficits or socially inappropriate
87.4 behavior; or
87.5 (iii) increased need for assistance for recipients who are verbally aggressive or
87.6 resistive to care so that time needed to perform activities of daily living is increased;
87.7 (5) back-up systems or mechanisms, such as the use of pagers or other electronic
87.8 devices, to ensure continuity of the participant's services and supports;
87.9 (6) transition costs, including:
87.10 (i) deposits for rent and utilities;
87.11 (ii) first month's rent and utilities;
87.12 (iii) bedding;
87.13 (iv) basic kitchen supplies;
87.14 (v) other necessities, to the extent that these necessities are not otherwise covered
87.15 under any other funding that the participant is eligible to receive; and
87.16 (vi) other required necessities for an individual to make the transition from a nursing
87.17 facility, institution for mental diseases, or intermediate care facility for persons with
87.18 developmental disabilities to a community-based home setting where the participant
87.19 resides; and
87.20 (7) services by a support specialist defined under subdivision 2 that are chosen
87.21 by the participant.
87.22 Subd. 8. **Determination of CFSS service methodology.** (a) All community first
87.23 services and supports must be authorized by the commissioner or the commissioner's
87.24 designee before services begin except for the assessments established in section
87.25 256B.0911. The authorization for CFSS must be completed within 30 days after receiving
87.26 a complete request.
87.27 (b) The amount of CFSS authorized must be based on the recipient's home
87.28 care rating. The home care rating shall be determined by the commissioner or the
87.29 commissioner's designee based on information submitted to the commissioner identifying
87.30 the following for a recipient:
87.31 (1) the total number of dependencies of activities of daily living as defined in
87.32 subdivision 2;
87.33 (2) the presence of complex health-related needs as defined in subdivision 2; and
87.34 (3) the presence of Level I behavior as defined in subdivision 2.
87.35 (c) For purposes meeting the criteria in paragraph (b), the methodology to determine
87.36 the total minutes for CFSS for each home care rating is based on the median paid units

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

88.4 (1) 30 additional minutes per day for a dependency in each critical activity of daily
88.5 living as defined in subdivision 2;

88.6 (2) 30 additional minutes per day for each complex health-related function as
88.7 defined in subdivision 2; and

88.8 (3) 30 additional minutes per day for each behavior issue as defined in subdivision 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

88.36 (8) medical supplies and equipment;

89.1 (9) environmental modifications, except as specified in subdivision 7;
89.2 (10) expenses for travel, lodging, or meals related to training the participant, the
89.3 participant's representative, legal representative, or paid or unpaid caregivers that exceed
89.4 $500 in a 12-month period;
89.5 (11) experimental treatments;
89.6 (12) any service or good covered by other medical assistance state plan services,
89.7 including prescription and over-the-counter medications, compounds, and solutions and
89.8 related fees, including premiums and co-payments;
89.9 (13) membership dues or costs, except when the service is necessary and appropriate
89.10 to treat a physical condition or to improve or maintain the participant's physical condition.
89.11 The condition must be identified in the participant's CFSS plan and monitored by a
89.12 physician enrolled in a Minnesota health care program;
89.13 (14) vacation expenses other than the cost of direct services;
89.14 (15) vehicle maintenance or modifications not related to the disability, health
89.15 condition, or physical need; and
89.16 (16) tickets and related costs to attend sporting or other recreational or entertainment
89.17 events.
89.18 Subd. 10. **Provider qualifications and general requirements.** (a)
89.19 Agency-providers delivering services under the agency-provider model under subdivision
89.20 11 or financial management service (FMS) contractors under subdivision 13 shall:
89.21 (1) enroll as a medical assistance Minnesota health care programs provider and meet
89.22 all applicable provider standards;
89.23 (2) comply with medical assistance provider enrollment requirements;
89.24 (3) demonstrate compliance with law and policies of CFSS as determined by the
89.25 commissioner;
89.26 (4) comply with background study requirements under chapter 245C;
89.27 (5) verify and maintain records of all services and expenditures by the participant,
89.28 including hours worked by support workers and support specialists;
89.29 (6) not engage in any agency-initiated direct contact or marketing in person, by
89.30 telephone, or other electronic means to potential participants, guardians, family member
89.31 or participants' representatives;
89.32 (7) pay support workers and support specialists based upon actual hours of services
89.33 provided;
89.34 (8) withhold and pay all applicable federal and state payroll taxes;
89.35 (9) make arrangements and pay unemployment insurance, taxes, workers'
89.36 compensation, liability insurance, and other benefits, if any;

90.1 (10) enter into a written agreement with the participant, participant's representative,
90.2 or legal representative that assigns roles and responsibilities to be performed before
90.3 services, supports, or goods are provided using a format established by the commissioner;
90.4 (11) report suspected neglect and abuse to the common entry point according to
90.5 sections 256B.0651 and 626.557; and
90.6 (12) provide the participant with a copy of the service-related rights under
90.7 subdivision 19 at the start of services and supports.
90.8 (b) The commissioner shall develop policies and procedures designed to ensure
90.9 program integrity and fiscal accountability for goods and services provided in this section.
90.10 Subd. 11. **Agency-provider model.** (a) The agency-provider model is limited to
90.11 the services provided by support workers and support specialists who are employed by
90.12 an agency-provider that is licensed according to chapter 245A or meets other criteria
90.13 established by the commissioner, including required training.
90.14 (b) The agency-provider shall allow the participant to retain the ability to have a
90.15 significant role in the selection and dismissal of the support workers for the delivery of the
90.16 services and supports specified in the service delivery plan.
90.17 (c) A participant may use authorized units of CFSS services as needed within
90.18 a service authorization that is not greater than 12 months. Using authorized units
90.19 agency-provider services or the budget allocation amount for the flexible spending model
90.20 flexibly does not increase the total amount of services and supports authorized for a
90.21 participant or included in the participant's service delivery plan.
90.22 (d) A participant may share CFSS services. Two or three CFSS participants may
90.23 share services at the same time provided by the same support worker.
90.24 (e) The agency-provider must use a minimum of 72.5 percent of the revenue
90.25 generated by the medical assistance payment for CFSS for support worker wages and
90.26 benefits. The agency-provider must document how this requirement is being met. The
90.27 revenue generated by the support specialist and the reasonable costs associated with the
90.28 support specialist must not be used in making this calculation.
90.29 (f) The agency-provider model must be used by individuals who have been restricted
90.30 by the Minnesota restricted recipient program.
90.31 Subd. 12. **Requirements for initial enrollment of CFSS provider agencies.** (a)
90.32 All CFSS provider agencies must provide, at the time of enrollment as a CFSS provider
90.33 agency in a format determined by the commissioner, information and documentation that
90.34 includes, but is not limited to, the following:
90.35 (1) the CFSS provider agency's current contact information including address,
90.36 telephone number, and e-mail address;

91.1 (2) proof of surety bond coverage in the amount of $50,000 or ten percent of the
91.2 provider's payments from Medicaid in the previous year, whichever is less;
91.3 (3) proof of fidelity bond coverage in the amount of $20,000;
91.4 (4) proof of workers' compensation insurance coverage;
91.5 (5) proof of liability insurance;
91.6 (6) a description of the CFSS provider agency's organization identifying the names
91.7 or all owners, managing employees, staff, board of directors, and the affiliations of the
91.8 directors, owners, or staff to other service providers;
91.9 (7) a copy of the CFSS provider agency's written policies and procedures including:
91.10 hiring of employees; training requirements; service delivery; and employee and consumer
91.11 safety including process for notification and resolution of consumer grievances,
91.12 identification and prevention of communicable diseases, and employee misconduct;
91.13 (8) copies of all other forms the CFSS provider agency uses in the course of daily
91.14 business including, but not limited to:
91.15 (i) a copy of the CFSS provider agency's time sheet if the time sheet varies from
91.16 the standard time sheet for CFSS services approved by the commissioner, and a letter
91.17 requesting approval of the CFSS provider agency's nonstandard time sheet;
91.18 (ii) the CFSS provider agency's template for the CFSS care plan; and
91.19 (iii) the CFSS provider agency's template for the written agreement in subdivision
91.20 21 for recipients using the CFSS choice option, if applicable;
91.21 (9) a list of all training and classes that the CFSS provider agency requires of its
91.22 staff providing CFSS services;
91.23 (10) documentation that the CFSS provider agency and staff have successfully
91.24 completed all the training required by this section;
91.25 (11) documentation of the agency's marketing practices;
91.26 (12) disclosure of ownership, leasing, or management of all residential properties
91.27 that is used or could be used for providing home care services;
91.28 (13) documentation that the agency will use the following percentages of revenue
91.29 generated from the medical assistance rate paid for CFSS services for employee personal
91.30 care assistant wages and benefits: 72.5 percent of revenue from CFSS providers. The
91.31 revenue generated by the support specialist and the reasonable costs associated with the
91.32 support specialist shall not be used in making this calculation; and
91.33 (14) documentation that the agency does not burden recipients' free exercise of their
91.34 right to choose service providers by requiring personal care assistants to sign an agreement
91.35 not to work with any particular CFSS recipient or for another CFSS provider agency after

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

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

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

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

92.21 (1) participants directly employ support workers;

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

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

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

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

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

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

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

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

92.36 (1) information and consultation about CFSS;

93.1 (2) assistance with the development of the service delivery plan and flexible
93.2 spending model as requested by the participant;
93.3 (3) billing and making payments for flexible spending model expenditures;
93.4 (4) assisting participants in fulfilling employer-related requirements according to
93.5 Internal Revenue Code Procedure 70-6, section 3504, Agency Employer Tax Liability,
93.6 regulation 137036-08, which includes assistance with filing and paying payroll taxes, and
93.7 obtaining worker compensation coverage;
93.8 (5) data recording and reporting of participant spending; and
93.9 (6) other duties established in the contract with the department.
93.10 (d) A participant who requests to purchase goods and supports along with support
93.11 worker services under the agency-provider model must use flexible spending model
93.12 with a service delivery plan that specifies the amount of services to be authorized to the
93.13 agency-provider and the expenditures to be paid by the FMS contractor.
93.14 (e) The FMS contractor shall:
93.15 (1) not limit or restrict the participant's choice of service or support providers or
93.16 service delivery models as authorized by the commissioner;
93.17 (2) provide the participant and the targeted case manager, if applicable, with a
93.18 monthly written summary of the spending for services and supports that were billed
93.19 against the spending budget;
93.20 (3) be knowledgeable of state and federal employment regulations under the Fair
93.21 Labor Standards Act of 1938, and comply with the requirements under the Internal
93.22 Revenue Service Revenue Code Procedure 70-6, Section 35-4, Agency Employer Tax
93.23 Liability for vendor or fiscal employer agent, and any requirements necessary to process
93.24 employer and employee deductions, provide appropriate and timely submission of
93.25 employer tax liabilities, and maintain documentation to support medical assistance claims;
93.26 (4) have current and adequate liability insurance and bonding and sufficient cash
93.27 flow as determined by the commission and have on staff or under contract a certified
93.28 public accountant or an individual with a baccalaureate degree in accounting;
93.29 (5) assume fiscal accountability for state funds designated for the program; and
93.30 (6) maintain documentation of receipts, invoices, and bills to track all services and
93.31 supports expenditures for any goods purchased and maintain time records of support
93.32 workers. The documentation and time records must be maintained for a minimum of
93.33 five years from the claim date and be available for audit or review upon request by the
93.34 commissioner. Claims submitted by the FMS contractor to the commissioner for payment
93.35 must correspond with services, amounts, and time periods as authorized in the participant's
93.36 spending budget and service plan.

94.1 (f) The commissioner of human services shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

95.14 (3) full name of the participant;

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

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

95.18 (6) personal signature of the support worker;

95.19 (7) any shared care provided, if applicable;

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

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

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

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

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

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

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

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

95.34 (4) not be a participant of CFSS;

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

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

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

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

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

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

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

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

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

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

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

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

96.31 Subd. 18. **Service unit and budget allocation requirements.** (a) For the
96.32 agency-provider model, services will be authorized in units of service. The total service
96.33 unit amount must be established based upon the assessed need for CFSS services, and
96.34 must not exceed the maximum number of units available as determined by section
96.35 256B.0652, subdivision 6. The unit rate established by the commissioner is used with
96.36 assessed units to determine the maximum available CFSS allocation.

97.1 (b) For the flexible spending model, services and supports are authorized under
97.2 a budget limit.
97.3 (c) The maximum available CFSS participant budget allocation shall be established
97.4 by multiplying the number of units authorized under subdivision 8 by the payment rate
97.5 established by the commissioner.
97.6 Subd. 19. **Support system.** (a) The commissioner shall provide information,
97.7 consultation, training, and assistance to ensure the participant is able to manage the
97.8 services and supports and budgets, if applicable. This support shall include individual
97.9 consultation on how to select and employ workers, manage responsibilities under CFSS,
97.10 and evaluate personal outcomes.
97.11 (b) The commissioner shall provide assistance with the development of risk
97.12 management agreements.
97.13 Subd. 20. **Service-related rights.** Participants must be provided with adequate
97.14 information, counseling, training, and assistance, as needed, to ensure that the participant
97.15 is able to choose and manage services, models, and budgets. This support shall include
97.16 information regarding: (1) person-centered planning; (2) the range and scope of individual
97.17 choices; (3) the process for changing plans, services and budgets; (4) the grievance
97.18 process; (5) individual rights; (6) identifying and assessing appropriate services; (7) risks
97.19 and responsibilities; and (8) risk management. A participant who appeals a reduction in
97.20 previously authorized CFSS services may continue previously authorized services pending
97.21 an appeal under section 256.045. The commissioner must ensure that the participant
97.22 has a copy of the most recent service delivery plan that contains a detailed explanation
97.23 of which areas of covered CFSS are reduced, and provide notice of the amount of the
97.24 budget reduction, and the reasons for the reduction in the participant's notice of denial,
97.25 termination, or reduction.
97.26 Subd. 21. **Development and Implementation Council.** The commissioner
97.27 shall establish a Development and Implementation Council of which the majority of
97.28 members are individuals with disabilities, elderly individuals, and their representatives.
97.29 The commissioner shall consult and collaborate with the council when developing and
97.30 implementing this section.
97.31 Subd. 22. **Quality assurance and risk management system.** (a) The commissioner
97.32 shall establish quality assurance and risk management measures for use in developing and
97.33 implementing CFSS including those that (1) recognize the roles and responsibilities of those
97.34 involved in obtaining CFSS, and (2) ensure the appropriateness of such plans and budgets
97.35 based upon a recipient's resources and capabilities. Risk management measures must
97.36 include background studies, and backup and emergency plans, including disaster planning.

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

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

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

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

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

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

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

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

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

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

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

98.34 Subd. 1o. **Supplementary service rate; exemptions.** A county agency shall not
98.35 negotiate a supplementary service rate under this section for any individual that has been

99.1 determined to be eligible for Housing Stability Services as approved by the Centers
99.2 for Medicare and Medicaid Services, and who resides in an establishment voluntarily
99.3 registered under section 144D.025, as a supportive housing establishment or participates
99.4 in the Minnesota supportive housing demonstration program under section 256I.04,
99.5 subdivision 3, paragraph (a), clause (4).

99.6 Sec. 45. Minnesota Statutes 2012, section 626.557, subdivision 4, is amended to read:
99.7 Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter
99.8 shall immediately make an oral report to the common entry point. The common entry
99.9 point may accept electronic reports submitted through a Web-based reporting system
99.10 established by the commissioner. Use of a telecommunications device for the deaf or other
99.11 similar device shall be considered an oral report. The common entry point may not require
99.12 written reports. To the extent possible, the report must be of sufficient content to identify
99.13 the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment,
99.14 any evidence of previous maltreatment, the name and address of the reporter, the time,
99.15 date, and location of the incident, and any other information that the reporter believes
99.16 might be helpful in investigating the suspected maltreatment. A mandated reporter may
99.17 disclose not public data, as defined in section 13.02, and medical records under sections
99.18 144.291 to 144.298, to the extent necessary to comply with this subdivision.
99.19 (b) A boarding care home that is licensed under sections 144.50 to 144.58 and
99.20 certified under Title 19 of the Social Security Act, a nursing home that is licensed under
99.21 section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a
99.22 hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under
99.23 Code of Federal Regulations, title 42, section 482.66, may submit a report electronically
99.24 to the common entry point instead of submitting an oral report. The report may be a
99.25 duplicate of the initial report the facility submits electronically to the commissioner of
99.26 health to comply with the reporting requirements under Code of Federal Regulations, title
99.27 42, section 483.13. The commissioner of health may modify these reporting requirements
99.28 to include items required under paragraph (a) that are not currently included in the
99.29 electronic reporting form.

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

99.31 Sec. 46. Minnesota Statutes 2012, section 626.557, subdivision 9, is amended to read:
99.32 Subd. 9. **Common entry point designation.** (a) ~~Each county board shall designate~~
99.33 ~~a common entry point for reports of suspected maltreatment. Two or more county boards~~
99.34 ~~may jointly designate a single~~ The commissioner of human services shall establish a

100.1 common entry point effective July 1, 2014. The common entry point is the unit responsible
100.2 for receiving the report of suspected maltreatment under this section.

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

100.6 (1) the time and date of the report;

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

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

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

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

100.12 (6) a description of the suspected maltreatment;

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

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

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

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

100.17 (11) whether law enforcement has been notified;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

101.21 Sec. 47. Minnesota Statutes 2012, section 626.557, subdivision 9e, is amended to read:

101.22 Subd. 9e. **Education requirements.** (a) The commissioners of health, human
101.23 services, and public safety shall cooperate in the development of a joint program for
101.24 education of lead investigative agency investigators in the appropriate techniques for
101.25 investigation of complaints of maltreatment. This program must be developed by July
101.26 1, 1996. The program must include but need not be limited to the following areas: (1)
101.27 information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4)
101.28 conclusions based on evidence; (5) interviewing skills, including specialized training to
101.29 interview people with unique needs; (6) report writing; (7) coordination and referral
101.30 to other necessary agencies such as law enforcement and judicial agencies; (8) human
101.31 relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family
101.32 systems and the appropriate methods for interviewing relatives in the course of the
101.33 assessment or investigation; (10) the protective social services that are available to protect
101.34 alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by
101.35 which lead investigative agency investigators and law enforcement workers cooperate in

102.1 conducting assessments and investigations in order to avoid duplication of efforts; and
102.2 (12) data practices laws and procedures, including provisions for sharing data.
102.3 (b) The commissioner of human services shall conduct an outreach campaign to
102.4 promote the common entry point for reporting vulnerable adult maltreatment. This
102.5 campaign shall use the Internet and other means of communication.
102.6 ~~(b)~~ (c) The commissioners of health, human services, and public safety shall offer at
102.7 least annual education to others on the requirements of this section, on how this section is
102.8 implemented, and investigation techniques.
102.9 ~~(c)~~ (d) The commissioner of human services, in coordination with the commissioner
102.10 of public safety shall provide training for the common entry point staff as required in this
102.11 subdivision and the program courses described in this subdivision, at least four times
102.12 per year. At a minimum, the training shall be held twice annually in the seven-county
102.13 metropolitan area and twice annually outside the seven-county metropolitan area. The
102.14 commissioners shall give priority in the program areas cited in paragraph (a) to persons
102.15 currently performing assessments and investigations pursuant to this section.
102.16 ~~(d)~~ (e) The commissioner of public safety shall notify in writing law enforcement
102.17 personnel of any new requirements under this section. The commissioner of public
102.18 safety shall conduct regional training for law enforcement personnel regarding their
102.19 responsibility under this section.
102.20 ~~(e)~~ (f) Each lead investigative agency investigator must complete the education
102.21 program specified by this subdivision within the first 12 months of work as a lead
102.22 investigative agency investigator.
102.23 A lead investigative agency investigator employed when these requirements take
102.24 effect must complete the program within the first year after training is available or as soon
102.25 as training is available.
102.26 All lead investigative agency investigators having responsibility for investigation
102.27 duties under this section must receive a minimum of eight hours of continuing education
102.28 or in-service training each year specific to their duties under this section.

102.29 Sec. 48. **REPEALER.**
102.30 (a) Minnesota Statutes 2012, sections 245A.655; and 256B.0917, subdivisions 1, 2,
102.31 3, 4, 5, 7, 8, 9, 10, 11, 12, and 14, are repealed.
102.32 (b) Minnesota Statutes 2012, section 256B.0911, subdivisions 4a, 4b, and 4c, are
102.33 repealed effective October 1, 2013.

103.1 Sec. 49. **EFFECTIVE DATE; CONTINGENT SYSTEMS MODERNIZATION**
103.2 **APPROPRIATION.**

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

103.5 (b) Unless otherwise indicated, "commissioner" means the commissioner of human
103.6 services.

103.7 (c) "Contingent systems modernization appropriation" refers to the appropriation in
103.8 article 15, section 3, subdivision 4, paragraph (a).

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

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

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

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

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

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

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

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

103.32 (2) include the contingent systems modernization appropriation, which cannot
103.33 exceed $16,992,000 for the biennium ending June 30, 2015; and

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

104.1 (c) Upon approval by the commissioner of management and budget, the department
104.2 may implement the plan.
104.3 (d) The commissioner may follow this plan and implement parts of Reform 2020
104.4 consistent with federal law if federal approval is denied, received incrementally, or
104.5 significantly delayed.
104.6 (e) The commissioner must notify the chairs and ranking minority members of the
104.7 legislative committees with jurisdiction over health and human services funding of the
104.8 plan. The plan must be made publicly available online.
104.9 Subd. 4. **Disbursement; implementation.** The commissioner of management and
104.10 budget shall disburse the appropriations in article 15, section 3, subdivision 4, paragraphs
104.11 (a), (b), and (d); subdivision 5, paragraphs (e), (g), and (h); and subdivision 6, paragraphs
104.12 (f), (i), and (k), to the commissioner to allow for implementation of the approved plan
104.13 and make necessary adjustments in the accounting system to reflect any modified funding
104.14 levels. Notwithstanding Minnesota Statutes, section 16A.11, subdivision 3, paragraph (b),
104.15 these fiscal estimates must be considered in establishing the appropriation base for the
104.16 biennium ending June 30, 2017. The commissioner of management and budget shall reflect
104.17 the modified funding levels in the first fund balance following the approval of the plan.

104.18 **ARTICLE 3**

104.19 **SAFE AND HEALTHY DEVELOPMENT OF CHILDREN**

104.20 Section 1. Minnesota Statutes 2012, section 119B.011, is amended by adding a
104.21 subdivision to read:
104.22 Subd. 19b. **Student parent.** "Student parent" means a person who is:
104.23 (1) under 21 years of age and has a child;
104.24 (2) pursuing a high school or general equivalency diploma;
104.25 (3) residing within a county that has a basic sliding fee waiting list under section
104.26 119B.03, subdivision 4; and
104.27 (4) not an MFIP participant.

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

104.29 Sec. 2. Minnesota Statutes 2012, section 119B.02, is amended by adding a subdivision
104.30 to read:
104.31 Subd. 7. **Child care market rate survey.** Biennially, the commissioner shall survey
104.32 prices charged by child care providers in Minnesota to determine the 75th percentile for
104.33 like-care arrangements in county price clusters.

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

105.2 Sec. 3. Minnesota Statutes 2012, section 119B.025, subdivision 1, is amended to read:
105.3 Subdivision 1. **Factors which must be verified.** (a) The county shall verify the
105.4 following at all initial child care applications using the universal application:
105.5 (1) identity of adults;
105.6 (2) presence of the minor child in the home, if questionable;
105.7 (3) relationship of minor child to the parent, stepparent, legal guardian, eligible
105.8 relative caretaker, or the spouses of any of the foregoing;
105.9 (4) age;
105.10 (5) immigration status, if related to eligibility;
105.11 (6) Social Security number, if given;
105.12 (7) income;
105.13 (8) spousal support and child support payments made to persons outside the
105.14 household;
105.15 (9) residence; and
105.16 (10) inconsistent information, if related to eligibility.
105.17 (b) If a family did not use the universal application or child care addendum to apply
105.18 for child care assistance, the family must complete the universal application or child care
105.19 addendum at its next eligibility redetermination and the county must verify the factors
105.20 listed in paragraph (a) as part of that redetermination. Once a family has completed a
105.21 universal application or child care addendum, the county shall use the redetermination
105.22 form described in paragraph (c) for that family's subsequent redeterminations. Eligibility
105.23 must be redetermined at least every six months. A family is considered to have met the
105.24 eligibility redetermination requirement if a complete redetermination form and all required
105.25 verifications are received within 30 days after the date the form was due. Assistance shall
105.26 be payable retroactively from the redetermination due date. For a family where at least
105.27 one parent is under the age of 21, does not have a high school or general equivalency
105.28 diploma, and is a student in a school district or another similar program that provides or
105.29 arranges for child care, as well as parenting, social services, career and employment
105.30 supports, and academic support to achieve high school graduation, the redetermination of
105.31 eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of
105.32 the student's school year. If a family reports a change in an eligibility factor before the
105.33 family's next regularly scheduled redetermination, the county must recalculate eligibility
105.34 without requiring verification of any eligibility factor that did not change.

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

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

106.5 Sec. 4. Minnesota Statutes 2012, section 119B.03, subdivision 4, is amended to read:
106.6 Subd. 4. **Funding priority.** (a) First priority for child care assistance under the
106.7 basic sliding fee program must be given to eligible non-MFIP families who do not have a
106.8 high school or general equivalency diploma or who need remedial and basic skill courses
106.9 in order to pursue employment or to pursue education leading to employment and who
106.10 need child care assistance to participate in the education program. This includes student
106.11 parents as defined under section 119B.011, subdivision 19b. Within this priority, the
106.12 following subpriorities must be used:
106.13 (1) child care needs of minor parents;
106.14 (2) child care needs of parents under 21 years of age; and
106.15 (3) child care needs of other parents within the priority group described in this
106.16 paragraph.
106.17 (b) Second priority must be given to parents who have completed their MFIP or
106.18 DWP transition year, or parents who are no longer receiving or eligible for diversionary
106.19 work program supports.
106.20 (c) Third priority must be given to families who are eligible for portable basic sliding
106.21 fee assistance through the portability pool under subdivision 9.
106.22 (d) Fourth priority must be given to families in which at least one parent is a veteran
106.23 as defined under section 197.447.
106.24 (e) Families under paragraph (b) must be added to the basic sliding fee waiting list
106.25 on the date they begin the transition year under section 119B.011, subdivision 20, and
106.26 must be moved into the basic sliding fee program as soon as possible after they complete
106.27 their transition year.

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

106.29 Sec. 5. Minnesota Statutes 2012, section 119B.05, subdivision 1, is amended to read:
106.30 Subdivision 1. **Eligible participants.** Families eligible for child care assistance
106.31 under the MFIP child care program are:
106.32 (1) MFIP participants who are employed or in job search and meet the requirements
106.33 of section 119B.10;

107.1 (2) persons who are members of transition year families under section 119B.011,
107.2 subdivision 20, and meet the requirements of section 119B.10;
107.3 (3) families who are participating in employment orientation or job search, or
107.4 other employment or training activities that are included in an approved employability
107.5 development plan under section 256J.95;
107.6 (4) MFIP families who are participating in work job search, job support,
107.7 employment, or training activities as required in their employment plan, or in appeals,
107.8 hearings, assessments, or orientations according to chapter 256J;
107.9 (5) MFIP families who are participating in social services activities under chapter
107.10 256J as required in their employment plan approved according to chapter 256J;
107.11 (6) families who are participating in services or activities that are included in an
107.12 approved family stabilization plan under section 256J.575;
107.13 (7) families who are participating in programs as required in tribal contracts under
107.14 section 119B.02, subdivision 2, or 256.01, subdivision 2; ~~and~~
107.15 (8) families who are participating in the transition year extension under section
107.16 119B.011, subdivision 20a~~.~~; and
107.17 (9) student parents as defined under section 119B.011, subdivision 19b.

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

107.19 Sec. 6. Minnesota Statutes 2012, section 119B.13, subdivision 1, is amended to read:
107.20 Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~October 31, 2011~~ September 16,
107.21 2013, the maximum rate paid for child care assistance in any county or ~~multicounty region~~
107.22 county price cluster under the child care fund shall be the ~~rate for like-care arrangements in~~
107.23 ~~the county effective July 1, 2006, decreased by 2.5 percent~~ greater of the 25th percentile of
107.24 the 2011 child care provider rate survey or the maximum rate effective November 28, 2011.
107.25 The commissioner may: (1) assign a county with no reported provider prices to a similar
107.26 price cluster; and (2) consider county level access when determining final price clusters.
107.27 ~~(b) Biennially, beginning in 2012, the commissioner shall survey rates charged~~
107.28 ~~by child care providers in Minnesota to determine the 75th percentile for like-care~~
107.29 ~~arrangements in counties. When the commissioner determines that, using the~~
107.30 ~~commissioner's established protocol, the number of providers responding to the survey is~~
107.31 ~~too small to determine the 75th percentile rate for like-care arrangements in a county or~~
107.32 ~~multicounty region, the commissioner may establish the 75th percentile maximum rate~~
107.33 ~~based on like-care arrangements in a county, region, or category that the commissioner~~
107.34 ~~deems to be similar.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

109.30 (b) If a provider has received an authorization of care and been issued a billing form
109.31 for an eligible family, the bill must be submitted within 60 days of the last date of service on
109.32 the bill. A bill submitted more than 60 days after the last date of service must be paid if the

110.1 county determines that the provider has shown good cause why the bill was not submitted
110.2 within 60 days. Good cause must be defined in the county's child care fund plan under
110.3 section 119B.08, subdivision 3, and the definition of good cause must include county error.
110.4 Any bill submitted more than a year after the last date of service on the bill must not be paid.

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

110.9 (d) A county may refuse to issue a child care authorization to a licensed or legal
110.10 nonlicensed provider, revoke an existing child care authorization to a licensed or legal
110.11 nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or
110.12 refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

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

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

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

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

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

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

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

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

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

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

111.1 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days
111.2 of receipt of the license holder's timely appeal, the commissioner shall request assignment
111.3 of an administrative law judge. The request must include a proposed date, time, and place
111.4 of a hearing. A hearing must be conducted by an administrative law judge within 30
111.5 calendar days of the request for assignment, unless an extension is requested by either
111.6 party and granted by the administrative law judge for good cause. The commissioner shall
111.7 issue a notice of hearing by certified mail or personal service at least ten working days
111.8 before the hearing. The scope of the hearing shall be limited solely to the issue of whether
111.9 the temporary immediate suspension should remain in effect pending the commissioner's
111.10 final order under section 245A.08, regarding a licensing sanction issued under subdivision
111.11 3 following the immediate suspension. The burden of proof in expedited hearings under
111.12 this subdivision shall be limited to the commissioner's demonstration that reasonable
111.13 cause exists to believe that the license holder's actions or failure to comply with applicable
111.14 law or rule poses, or if the actions of other individuals or conditions in the program poses
111.15 an imminent risk of harm to the health, safety, or rights of persons served by the program.
111.16 "Reasonable cause" means there exist specific articulable facts or circumstances which
111.17 provide the commissioner with a reasonable suspicion that there is an imminent risk of harm
111.18 to the health, safety, or rights of persons served by the program. When the commissioner
111.19 has determined there is reasonable cause to order the temporary immediate suspension of
111.20 a license based on a violation of safe sleep requirements, the commissioner is not required
111.21 to demonstrate that an infant died or was injured as a result of the safe sleep violations.
111.22 (b) The administrative law judge shall issue findings of fact, conclusions, and a
111.23 recommendation within ten working days from the date of hearing. The parties shall have
111.24 ten calendar days to submit exceptions to the administrative law judge's report. The
111.25 record shall close at the end of the ten-day period for submission of exceptions. The
111.26 commissioner's final order shall be issued within ten working days from the close of the
111.27 record. Within 90 calendar days after a final order affirming an immediate suspension, the
111.28 commissioner shall make a determination regarding whether a final licensing sanction
111.29 shall be issued under subdivision 3. The license holder shall continue to be prohibited
111.30 from operation of the program during this 90-day period.
111.31 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
111.32 final licensing sanction is issued under subdivision 3 and the license holder appeals that
111.33 sanction, the license holder continues to be prohibited from operation of the program
111.34 pending a final commissioner's order under section 245A.08, subdivision 5, regarding the
111.35 final licensing sanction.

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

112.2 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT**
112.3 **DEATH ~~SYNDROME~~ IN LICENSED PROGRAMS.**

112.4 (a) When a license holder is placing an infant to sleep, the license holder must
112.5 place the infant on the infant's back, unless the license holder has documentation from
112.6 the infant's ~~parent~~ physician directing an alternative sleeping position for the infant. The
112.7 ~~parent~~ physician directive must be on a form approved by the commissioner and must
112.8 ~~include a statement that the parent or legal guardian has read the information provided by~~
112.9 ~~the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance~~
112.10 ~~of placing an infant or child on its back to sleep to reduce the risk of SIDS~~ remain on file
112.11 at the licensed location. An infant who independently rolls onto its stomach after being
112.12 placed to sleep on its back may be allowed to remain sleeping on its stomach.

112.13 (b) The license holder must place the infant in a crib directly on a firm mattress with
112.14 a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be
112.15 dislodged by pulling on the corner of the sheet. The license holder must not place pillows,
112.16 quilts, comforters, sheepskin, pillow-like stuffed toys, any loose bedding including but
112.17 not limited to blankets and sheets, or other soft products in the crib with the infant. The
112.18 requirements of this section apply to license holders serving infants up to and including
112.19 12 months of age. Licensed child care providers must meet the crib requirements under
112.20 section 245A.146.

112.21 (c) If an infant falls asleep before being placed in a crib, the license holder must
112.22 move the infant to a crib as soon as practicable, and must keep the infant within sight of
112.23 the license holder until the infant is placed in a crib. When an infant falls asleep while
112.24 being held, the license holder must consider the supervision needs of other children in
112.25 care when determining how long to hold the infant before placing the infant in a crib to
112.26 sleep. The sleeping infant must not be in a position where the airway may be blocked or
112.27 with anything covering the infant's face.

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

112.29 **245A.144 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
112.30 **DEATH AND ~~SHAKEN BABY SYNDROME~~ ABUSIVE HEAD TRAUMA FOR**
112.31 **CHILD FOSTER CARE PROVIDERS.**

112.32 (a) Licensed child foster care providers that care for infants or children through five
112.33 years of age must document that before staff persons and caregivers assist in the care
112.34 of infants or children through five years of age, they are instructed on the standards in
112.35 section 245A.1435 and receive training on reducing the risk of sudden unexpected infant

113.1 death ~~syndrome~~ and ~~shaken baby syndrome for~~ abusive head trauma from shaking infants
113.2 and young children. This section does not apply to emergency relative placement under
113.3 section 245A.035. The training on reducing the risk of sudden unexpected infant death
113.4 ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma may be provided as:
113.5 (1) orientation training to child foster care providers, who care for infants or children
113.6 through five years of age, under Minnesota Rules, part 2960.3070, subpart 1; or
113.7 (2) in-service training to child foster care providers, who care for infants or children
113.8 through five years of age, under Minnesota Rules, part 2960.3070, subpart 2.
113.9 (b) Training required under this section must be at least one hour in length and must
113.10 be completed at least once every five years. At a minimum, the training must address
113.11 the risk factors related to sudden unexpected infant death ~~syndrome~~ and ~~shaken baby~~
113.12 ~~syndrome~~ abusive head trauma, means of reducing the risk of sudden unexpected infant
113.13 death ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma, and license holder
113.14 communication with parents regarding reducing the risk of sudden unexpected infant
113.15 death ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma.
113.16 (c) Training for child foster care providers must be approved by the county or
113.17 private licensing agency that is responsible for monitoring the child foster care provider
113.18 under section 245A.16. The approved training fulfills, in part, training required under
113.19 Minnesota Rules, part 2960.3070.

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

113.21 **245A.1444 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
113.22 **DEATH ~~SYNDROME~~ AND ~~SHAKEN BABY SYNDROME~~ ABUSIVE HEAD**
113.23 **TRAUMA BY OTHER PROGRAMS.**

113.24 A licensed chemical dependency treatment program that serves clients with infants
113.25 or children through five years of age, who sleep at the program and a licensed children's
113.26 residential facility that serves infants or children through five years of age, must document
113.27 that before program staff persons or volunteers assist in the care of infants or children
113.28 through five years of age, they are instructed on the standards in section 245A.1435 and
113.29 receive training on reducing the risk of sudden unexpected infant death ~~syndrome~~ and
113.30 ~~shaken baby syndrome~~ abusive head trauma from shaking infants and young children. The
113.31 training conducted under this section may be used to fulfill training requirements under
113.32 Minnesota Rules, parts 2960.0100, subpart 3; and 9530.6490, subpart 4, item B.
113.33 This section does not apply to child care centers or family child care programs
113.34 governed by sections 245A.40 and 245A.50.

114.1 Sec. 15. **[245A.147] FAMILY CHILD CARE INFANT SLEEP SUPERVISION**
114.2 **REQUIREMENTS.**
114.3 Subdivision 1. **In-person checks on infants.** (a) License holders that serve infants
114.4 must monitor sleeping infants by conducting in-person checks on each infant in their care
114.5 every 30 minutes.
114.6 (b) Upon enrollment of an infant in a family child care program, the license holder
114.7 must conduct in-person checks on the infant every 15 minutes, during the first four
114.8 months of care.
114.9 (c) When an infant has an upper respiratory infection, the license holder must
114.10 conduct in-person checks on the infant every 15 minutes throughout the hours of care.
114.11 Subd. 2. **Use of audio or visual monitoring devices.** In addition to conducting
114.12 the in-person checks required under subdivision 1, license holders serving infants must
114.13 use and maintain an audio or visual monitoring device to monitor each infant in care
114.14 during all hours of care.

114.15 Sec. 16. **[245A.152] CHILD CARE LICENSE HOLDER INSURANCE.**
114.16 Subdivision 1. **Insurance coverage required for child care licensure.** (a) All
114.17 licensed family child care providers and child care centers shall maintain insurance
114.18 coverage for personal injury, death, or property damage resulting from any act or omission
114.19 related to the provision of services under the license. The coverage limits shall be at least
114.20 $100,000 per person and $250,000 per occurrence.
114.21 (b) No license to provide child care shall take effect before the insurance coverage
114.22 required under this section becomes effective. A license shall be suspended or revoked
114.23 any time the insurance coverage required under this section lapses or is terminated and
114.24 replacement coverage has not taken effect.
114.25 (c) A license holder shall immediately notify the commissioner if the insurance
114.26 coverage required under this section lapses or is terminated and no replacement coverage
114.27 has taken effect.
114.28 Subd. 2. **Evidence of insurance.** (a) A current certificate of coverage for insurance
114.29 required under this section shall be posted in a place in the licensed family child care
114.30 home or center that is conspicuous to all visitors and parents of children receiving services
114.31 from the program.
114.32 (b) A license holder shall, upon request, provide a copy of the current certificate of
114.33 coverage for insurance required under this section to the commissioner or to any parent
114.34 of a child receiving services from the licensed program.

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

Subd. 5. **Sudden unexpected infant death ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma training.** (a) License holders must document that before staff persons and volunteers care for infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death ~~syndrome~~. In addition, license holders must document that before staff persons care for infants or children under school age, they receive training on the risk of ~~shaken baby syndrome~~ abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as orientation training under subdivision 1 and in-service training under subdivision 7.

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

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

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

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

245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.

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

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

116.1 Subd. 2. **Child growth and development and behavior guidance training.** (a) For
116.2 purposes of family and group family child care, the license holder and each adult caregiver
116.3 who provides care in the licensed setting for more than 30 days in any 12-month period
116.4 shall complete and document at least ~~two~~ four hours of child growth and development
116.5 and behavior guidance training ~~within the first year of~~ prior to initial licensure, and before
116.6 caring for children. For purposes of this subdivision, "child growth and development
116.7 training" means training in understanding how children acquire language and develop
116.8 physically, cognitively, emotionally, and socially. "Behavior guidance training" means
116.9 training in the understanding of the functions of child behavior and strategies for managing
116.10 challenging situations. Child growth and development and behavior guidance training
116.11 must be repeated annually. Training curriculum shall be developed by the commissioner
116.12 of human services by January 1, 2014.

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

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

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

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

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

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

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

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

117.1 Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family
117.2 child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least
117.3 one staff person must be present in the home who has been trained in cardiopulmonary
117.4 resuscitation (CPR) and in the treatment of obstructed airways that includes CPR
117.5 techniques for infants and children. The CPR training must have been provided by an
117.6 individual approved to provide CPR instruction, must be repeated at least once every three
117.7 two years, and must be documented in the staff person's records.
117.8 (b) A family child care provider is exempt from the CPR training requirement in
117.9 this subdivision related to any substitute caregiver who provides less than 30 hours of
117.10 care during any 12-month period.
117.11 (c) Video training reviewed and approved by the county licensing agency satisfies
117.12 the training requirement of this subdivision. Persons providing CPR training must use
117.13 CPR training that has been developed:
117.14 (1) by the American Heart Association or the American Red Cross and incorporates
117.15 psychomotor skills to support the instruction; or
117.16 (2) using nationally recognized, evidence-based guidelines for CPR training and
117.17 incorporates psychomotor skills to support the instruction.
117.18 Subd. 5. **Sudden unexpected infant death syndrome and shaken baby syndrome**
117.19 **abusive head trauma training.** (a) License holders must document that before staff
117.20 persons, caregivers, and helpers assist in the care of infants, they are instructed on the
117.21 standards in section 245A.1435 and receive training on reducing the risk of sudden
117.22 unexpected infant death syndrome. In addition, license holders must document that before
117.23 staff persons, caregivers, and helpers assist in the care of infants and children under
117.24 school age, they receive training on reducing the risk of shaken baby syndrome abusive
117.25 head trauma from shaking infants and young children. The training in this subdivision
117.26 may be provided as initial training under subdivision 1 or ongoing annual training under
117.27 subdivision 7.
117.28 (b) Sudden unexpected infant death syndrome reduction training required under
117.29 this subdivision must be at least one-half hour in length and must be completed at least
117.30 once every five years year. At a minimum, the training must address the risk factors
117.31 related to sudden unexpected infant death syndrome, means of reducing the risk of sudden
117.32 unexpected infant death syndrome in child care, and license holder communication with
117.33 parents regarding reducing the risk of sudden unexpected infant death syndrome.
117.34 (c) Shaken baby syndrome Abusive head trauma training required under this
117.35 subdivision must be at least one-half hour in length and must be completed at least once
117.36 every five years year. At a minimum, the training must address the risk factors related

to ~~shaken baby syndrome~~ shaking infants and young children, means of reducing the risk of ~~shaken baby syndrome~~ abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive head trauma.

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

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

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

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

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

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

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

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

Subd. 7. **Training requirements for family and group family child care.** For purposes of family and group family child care, the license holder and each primary caregiver must complete ~~eight~~ 16 hours of ongoing training each year. For purposes of this subdivision, a primary caregiver is an adult caregiver who provides services in the licensed setting for more than 30 days in any 12-month period. Repeat of topical training requirements in subdivisions 2 to 7 shall count toward the annual 16-hour training requirement. Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from the following areas:

(1) ~~"~~child growth and development training~~" has the meaning given in~~ under subdivision 2, paragraph (a);

(2) ~~"~~learning environment and curriculum~~" includes~~, including training in establishing an environment and providing activities that provide learning experiences to meet each child's needs, capabilities, and interests;

(3) ~~"~~assessment and planning for individual needs~~" includes~~, including training in observing and assessing what children know and can do in order to provide curriculum and instruction that addresses their developmental and learning needs, including children with special needs and bilingual children or children for whom English is not their primary language;

(4) ~~"~~interactions with children~~" includes~~, including training in establishing supportive relationships with children, guiding them as individuals and as part of a group;

(5) ~~"~~families and communities~~" includes~~, including training in working collaboratively with families and agencies or organizations to meet children's needs and to encourage the community's involvement;

(6) ~~"~~health, safety, and nutrition~~" includes~~, including training in establishing and maintaining an environment that ensures children's health, safety, and nourishment, including child abuse, maltreatment, prevention, and reporting; home and fire safety; child injury prevention; communicable disease prevention and control; first aid; and CPR; and

(7) ~~"~~program planning and evaluation~~" includes~~, including training in establishing, implementing, evaluating, and enhancing program operations.

Subd. 8. **Other required training requirements.** (a) The training required of family and group family child care providers and staff must include training in the cultural dynamics of early childhood development and child care. The cultural dynamics and disabilities training and skills development of child care providers must be designed to achieve outcomes for providers of child care that include, but are not limited to:

(1) an understanding and support of the importance of culture and differences in ability in children's identity development;

120.1 (2) understanding the importance of awareness of cultural differences and
120.2 similarities in working with children and their families;
120.3 (3) understanding and support of the needs of families and children with differences
120.4 in ability;
120.5 (4) developing skills to help children develop unbiased attitudes about cultural
120.6 differences and differences in ability;
120.7 (5) developing skills in culturally appropriate caregiving; and
120.8 (6) developing skills in appropriate caregiving for children of different abilities.
120.9 The commissioner shall approve the curriculum for cultural dynamics and disability
120.10 training.
120.11 (b) The provider must meet the training requirement in section 245A.14, subdivision
120.12 11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child
120.13 care or group family child care home to use the swimming pool located at the home.
120.14 Subd. 9. **Supervising for safety; training requirement.** Effective July 1, 2014,
120.15 all family child care license holders and each adult caregiver who provides care in the
120.16 licensed family child care home for more than 30 days in any 12-month period shall
120.17 complete and document at least six hours approved training on supervising for safety
120.18 prior to initial licensure, and before caring for children. At least two hours of training
120.19 on supervising for safety must be repeated annually. For purposes of this subdivision,
120.20 "supervising for safety" includes supervision basics, supervision outdoors, equipment and
120.21 materials, illness, injuries, and disaster preparedness. The commissioner shall develop
120.22 the supervising for safety curriculum by January 1, 2014.

120.23 Sec. 19. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:
120.24 Subdivision 1. **Background studies conducted by Department of Human**
120.25 **Services.** (a) For a background study conducted by the Department of Human Services,
120.26 the commissioner shall review:
120.27 (1) information related to names of substantiated perpetrators of maltreatment of
120.28 vulnerable adults that has been received by the commissioner as required under section
120.29 626.557, subdivision 9c, paragraph (j);
120.30 (2) the commissioner's records relating to the maltreatment of minors in licensed
120.31 programs, and from findings of maltreatment of minors as indicated through the social
120.32 service information system;
120.33 (3) information from juvenile courts as required in subdivision 4 for individuals
120.34 listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;
120.35 (4) information from the Bureau of Criminal Apprehension;

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

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

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

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

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

121.15 Sec. 20. Minnesota Statutes 2012, section 245C.33, subdivision 1, is amended to read:

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

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

121.26 Sec. 21. Minnesota Statutes 2012, section 256.0112, is amended by adding a
121.27 subdivision to read:

121.28 Subd. 10. **Contracts for child foster care services.** When local agencies negotiate
121.29 lead county contracts or purchase of service contracts for child foster care services, the
121.30 foster care maintenance payment made on behalf of the child shall follow the provisions of
121.31 Northstar Care for Children, chapter 256N. Foster care maintenance payments as defined
121.32 in section 256N.02, subdivision 15, represents costs for activities similar in nature to those
121.33 expected of parents and do not cover services rendered by the licensed or tribally approved
121.34 foster parent, facility, or administrative costs or fees. Payments made to foster parents

122.1 must follow the requirements of section 256N.26, subdivision 15. The legally responsible
122.2 agency must provide foster parents with the assessment and notice as specified in section
122.3 256N.24. The financially responsible agency is permitted to make additional payments for
122.4 specific services provided by the foster parents or facility, as permitted in section 256N.21,
122.5 subdivision 5. These additional payments are not considered foster care maintenance.

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

122.14 Sec. 23. Minnesota Statutes 2012, section 256.82, subdivision 3, is amended to read:
122.15 Subd. 3. **Setting foster care standard rates.** (a) The commissioner shall annually
122.16 establish minimum standard maintenance rates for foster care maintenance and including
122.17 supplemental difficulty of care payments for all children in foster care eligible for
122.18 Northstar Care for Children under chapter 256N.
122.19 (b) All children entering foster care on or after January 1, 2015, are eligible for
122.20 Northstar Care for Children under chapter 256N. Any increase in rates shall in no case
122.21 exceed three percent per annum.
122.22 (c) All children in foster care on December 31, 2014, must remain in the
122.23 pre-Northstar Care for Children foster care program under sections 256N.21, subdivision
122.24 6, and 260C.4411, subdivision 1. The rates for the pre-Northstar Care for Children foster
122.25 care program shall remain those in effect on January 1, 2013.

122.26 Sec. 24. Minnesota Statutes 2012, section 256.98, subdivision 8, is amended to read:
122.27 Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of
122.28 wrongfully obtaining assistance by a federal or state court or by an administrative hearing
122.29 determination, or waiver thereof, through a disqualification consent agreement, or as part
122.30 of any approved diversion plan under section 401.065, or any court-ordered stay which
122.31 carries with it any probationary or other conditions, in the Minnesota family investment
122.32 program and any affiliated program to include the diversionary work program and the
122.33 work participation cash benefit program, the food stamp or food support program, the

123.1 general assistance program, the group residential housing program, or the Minnesota
123.2 supplemental aid program shall be disqualified from that program. In addition, any person
123.3 disqualified from the Minnesota family investment program shall also be disqualified from
123.4 the food stamp or food support program. The needs of that individual shall not be taken
123.5 into consideration in determining the grant level for that assistance unit:

123.6 (1) for one year after the first offense;

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

123.8 (3) permanently after the third or subsequent offense.

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

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

123.31 (c) A provider caring for children receiving assistance through child care assistance
123.32 programs under chapter 119B is disqualified from receiving payment for child care
123.33 services from the child care assistance program under chapter 119B when the provider is
123.34 found to have wrongfully obtained child care assistance by a federal court, state court,
123.35 or an administrative hearing determination or waiver under section 256.046, through
123.36 a disqualification consent agreement, as part of an approved diversion plan under

124.1 section 401.065, or a court-ordered stay with probationary or other conditions. The
124.2 disqualification must be for a period of one year for the first offense and two years for
124.3 the second offense. Any subsequent violation must result in permanent disqualification.
124.4 The disqualification period must be imposed immediately after a determination is made
124.5 under this paragraph. During the disqualification period, the provider is disqualified from
124.6 receiving payment from any child care program under chapter 119B.

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

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

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

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

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

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

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

125.3 (1) payments for basic care, difficulty of care, and clothing allowances received for
125.4 providing family foster care to children or adults under Minnesota Rules, parts 9555.5050
125.5 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, payments for family foster care to
125.6 children under chapter 256N, and payments received and used for care and maintenance of
125.7 a third-party beneficiary who is not a household member;

125.8 (2) reimbursements for employment training received through the Workforce
125.9 Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

125.10 (3) reimbursement for out-of-pocket expenses incurred while performing volunteer
125.11 services, jury duty, employment, or informal carpooling arrangements directly related to
125.12 employment;

125.13 (4) all educational assistance, except the county agency must count graduate student
125.14 teaching assistantships, fellowships, and other similar paid work as earned income and,
125.15 after allowing deductions for any unmet and necessary educational expenses, shall
125.16 count scholarships or grants awarded to graduate students that do not require teaching
125.17 or research as unearned income;

125.18 (5) loans, regardless of purpose, from public or private lending institutions,
125.19 governmental lending institutions, or governmental agencies;

125.20 (6) loans from private individuals, regardless of purpose, provided an applicant or
125.21 participant documents that the lender expects repayment;

125.22 (7)(i) state income tax refunds; and

125.23 (ii) federal income tax refunds;

125.24 (8)(i) federal earned income credits;

125.25 (ii) Minnesota working family credits;

125.26 (iii) state homeowners and renters credits under chapter 290A; and

125.27 (iv) federal or state tax rebates;

125.28 (9) funds received for reimbursement, replacement, or rebate of personal or real
125.29 property when these payments are made by public agencies, awarded by a court, solicited
125.30 through public appeal, or made as a grant by a federal agency, state or local government,
125.31 or disaster assistance organizations, subsequent to a presidential declaration of disaster;

125.32 (10) the portion of an insurance settlement that is used to pay medical, funeral, and
125.33 burial expenses, or to repair or replace insured property;

125.34 (11) reimbursements for medical expenses that cannot be paid by medical assistance;

125.35 (12) payments by a vocational rehabilitation program administered by the state
125.36 under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) ~~state adoption assistance payments under section 259.67, and up to an equal amount of county adoption assistance payments~~ adoption assistance payments under chapter 259A and Minnesota Permanency Demonstration, Title IV-E waiver payments under section 256.01, subdivision 14a;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

127.1 (31) reverse mortgages;

127.2 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title
127.3 42, chapter 13A, sections 1771 to 1790;

127.4 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
127.5 United States Code, title 42, chapter 13A, section 1786;

127.6 (34) benefits from the National School Lunch Act, United States Code, title 42,
127.7 chapter 13, sections 1751 to 1769e;

127.8 (35) relocation assistance for displaced persons under the Uniform Relocation
127.9 Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title
127.10 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States
127.11 Code, title 12, chapter 13, sections 1701 to 1750jj;

127.12 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter
127.13 12, part 2, sections 2271 to 2322;

127.14 (37) war reparations payments to Japanese Americans and Aleuts under United
127.15 States Code, title 50, sections 1989 to 1989d;

127.16 (38) payments to veterans or their dependents as a result of legal settlements
127.17 regarding Agent Orange or other chemical exposure under Public Law 101-239, section
127.18 10405, paragraph (a)(2)(E);

127.19 (39) income that is otherwise specifically excluded from MFIP consideration in
127.20 federal law, state law, or federal regulation;

127.21 (40) security and utility deposit refunds;

127.22 (41) American Indian tribal land settlements excluded under Public Laws 98-123,
127.23 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech
127.24 Lake, and Mille Lacs reservations and payments to members of the White Earth Band,
127.25 under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

127.26 (42) all income of the minor parent's parents and stepparents when determining the
127.27 grant for the minor parent in households that include a minor parent living with parents or
127.28 stepparents on MFIP with other children;

127.29 (43) income of the minor parent's parents and stepparents equal to 200 percent of the
127.30 federal poverty guideline for a family size not including the minor parent and the minor
127.31 parent's child in households that include a minor parent living with parents or stepparents
127.32 not on MFIP when determining the grant for the minor parent. The remainder of income is
127.33 deemed as specified in section 256J.37, subdivision 1b;

127.34 (44) payments made to children eligible for relative custody assistance under section
127.35 257.85 and guardianship assistance under section 256N.20;

128.1 (45) vendor payments for goods and services made on behalf of a client unless the
128.2 client has the option of receiving the payment in cash;

128.3 (46) the principal portion of a contract for deed payment; and

128.4 (47) cash payments to individuals enrolled for full-time service as a volunteer under
128.5 AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps
128.6 National, and AmeriCorps NCCC.

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

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

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

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

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

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

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

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

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

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

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

129.3 Sec. 28. Minnesota Statutes 2012, section 256J.24, subdivision 3, is amended to read:
129.4 Subd. 3. **Individuals who must be excluded from an assistance unit.** (a) The
129.5 following individuals who are part of the assistance unit determined under subdivision 2
129.6 are ineligible to receive MFIP:
129.7 (1) individuals who are recipients of Supplemental Security Income or Minnesota
129.8 supplemental aid;
129.9 (2) individuals disqualified from the food stamp or food support program or MFIP,
129.10 until the disqualification ends;
129.11 (3) children on whose behalf federal, state or local foster care payments are made,
129.12 except as provided in sections 256J.13, subdivision 2, and 256J.74, subdivision 2;
129.13 (4) children receiving ongoing guardianship assistance payments under chapter 256N;
129.14 ~~(4)~~ (5) children receiving ongoing monthly adoption assistance payments under
129.15 ~~section 259.67~~ chapter 259A or 256N; and
129.16 ~~(5)~~ (6) individuals disqualified from the work participation cash benefit program
129.17 until that disqualification ends.
129.18 (b) The exclusion of a person under this subdivision does not alter the mandatory
129.19 assistance unit composition.

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

129.21 Sec. 29. Minnesota Statutes 2012, section 256J.24, subdivision 7, is amended to read:
129.22 Subd. 7. **Family wage level.** The family wage level is 110 percent of the transitional
129.23 standard under subdivision 5 or 6~~, when applicable, and is the standard used when there is~~
129.24 ~~earned income in the assistance unit. As specified in section 256J.21~~. If there is earned
129.25 income in the assistance unit, earned income is subtracted from the family wage level to
129.26 determine the amount of the assistance payment, as specified in section 256J.21. The
129.27 assistance payment may not exceed the transitional standard under subdivision 5 or 6,
129.28 or the shared household standard under subdivision 9, whichever is applicable, for the
129.29 assistance unit.

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

130.1 Sec. 30. Minnesota Statutes 2012, section 256J.621, is amended to read:

130.2 **256J.621 WORK PARTICIPATION CASH BENEFITS.**

130.3 Subdivision 1. **Program characteristics.** (a) Effective October 1, 2009, upon
130.4 exiting the diversionary work program (DWP) or upon terminating the Minnesota family
130.5 investment program with earnings, a participant who is employed may be eligible for work
130.6 participation cash benefits of $25 per month to assist in meeting the family's basic needs
130.7 as the participant continues to move toward self-sufficiency.

130.8 (b) To be eligible for work participation cash benefits, the participant shall not
130.9 receive MFIP or diversionary work program assistance during the month and the
130.10 participant or participants must meet the following work requirements:

130.11 (1) if the participant is a single caregiver and has a child under six years of age, the
130.12 participant must be employed at least 87 hours per month;

130.13 (2) if the participant is a single caregiver and does not have a child under six years of
130.14 age, the participant must be employed at least 130 hours per month; or

130.15 (3) if the household is a two-parent family, at least one of the parents must be
130.16 employed 130 hours per month.

130.17 Whenever a participant exits the diversionary work program or is terminated from
130.18 MFIP and meets the other criteria in this section, work participation cash benefits are
130.19 available for up to 24 consecutive months.

130.20 (c) Expenditures on the program are maintenance of effort state funds under
130.21 a separate state program for participants under paragraph (b), clauses (1) and (2).
130.22 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort
130.23 funds. Months in which a participant receives work participation cash benefits under this
130.24 section do not count toward the participant's MFIP 60-month time limit.

130.25 Subd. 2. **Program suspension.** (a) Effective December 1, 2013, the work
130.26 participation cash benefits program shall be suspended.

130.27 (b) The commissioner of human services may reinstate the work participation cash
130.28 benefits program if the United States Department of Human Services determines that the
130.29 state of Minnesota did not meet the federal TANF work participation rate, and sends a
130.30 notice of penalty to reduce Minnesota's federal TANF block grant authorized under title I
130.31 of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation
130.32 Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005.

130.33 (c) The commissioner shall notify the chairs of the legislative committees with
130.34 jurisdiction over human services policy and funding of the potential penalty and the
130.35 commissioner's plans to reinstate the work participation cash benefit program within 30

days of the date the commissioner receives notification that the state failed to meet the federal work participation rate.

Sec. 31. Minnesota Statutes 2012, section 256J.626, subdivision 7, is amended to read:

Subd. 7. **Performance base funds.** ~~(a) For the purpose of this section, the following terms have the meanings given.~~

~~(1) "Caseload Reduction Credit" (CRC) means the measure of how much Minnesota TANF and separate state program caseload has fallen relative to federal fiscal year 2005 based on caseload data from October 1 to September 30.~~

~~(2) "TANF participation rate target" means a 50 percent participation rate reduced by the CRC for the previous year.~~

~~(b)~~ (a) For calendar year ~~2010~~ 2016 and yearly thereafter, each county and tribe ~~will~~ must be allocated ~~95~~ 100 percent of their initial calendar year allocation. Allocations for counties and tribes ~~will~~ must be ~~allocated additional funds~~ adjusted based on performance as follows:

~~(1) a county or tribe that achieves the TANF participation rate target or a five percentage point improvement over the previous year's TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation;~~

~~(2)~~ (1) a county or tribe that performs ~~within or~~ above its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), ~~will~~ must receive an additional allocation equal to 2.5 percent of its initial allocation; and

~~(3) a county or tribe that does not achieve the TANF participation rate target or a five percentage point improvement over the previous year's TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for the most recent year for which the measurements are available, will not receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear improvement plan with the commissioner; or~~

~~(4)~~ (2) a county or tribe that ~~does not perform within or above~~ performs below its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal to 2.5 percent of its initial allocation until after negotiating~~ for two consecutive years must negotiate a multiyear improvement plan with the commissioner. If no improvement is shown by the end of the multiyear plan, the county's or tribe's allocation must be decreased

132.1 by 2.5 percent. The decrease must remain in effect until the county or tribe performs
132.2 within or above its range of expected performance.
132.3 (c) (b) For calendar year 2009 2016 and yearly thereafter, performance-based funds
132.4 for a federally approved tribal TANF program in which the state and tribe have in place a
132.5 contract under section 256.01, addressing consolidated funding, will must be allocated
132.6 as follows:
132.7 (1) a tribe that achieves the participation rate approved in its federal TANF plan
132.8 using the average of 12 consecutive months for the most recent year for which the
132.9 measurements are available, will receive an additional allocation equal to 2.5 percent of
132.10 its initial allocation; and
132.11 (2) (1) a tribe that performs within or above its range of expected performance on the
132.12 annualized three-year self-support index under section 256J.751, subdivision 2, clause (6),
132.13 will must receive an additional allocation equal to 2.5 percent of its initial allocation; or
132.14 (3) a tribe that does not achieve the participation rate approved in its federal TANF
132.15 plan using the average of 12 consecutive months for the most recent year for which the
132.16 measurements are available, will not receive an additional allocation equal to 2.5 percent
132.17 of its initial allocation until after negotiating a multiyear improvement plan with the
132.18 commissioner; or
132.19 (4) (2) a tribe that does not perform within or above performs below its range of
132.20 expected performance on the annualized three-year self-support index under section
132.21 256J.751, subdivision 2, clause (6), will not receive an additional allocation equal to
132.22 2.5 percent until after negotiating for two consecutive years must negotiate a multiyear
132.23 improvement plan with the commissioner. If no improvement is shown by the end of the
132.24 multiyear plan, the tribe's allocation must be decreased by 2.5 percent. The decrease must
132.25 remain in effect until the tribe performs within or above its range of expected performance.
132.26 (d) (c) Funds remaining unallocated after the performance-based allocations
132.27 in paragraph (b) (a) are available to the commissioner for innovation projects under
132.28 subdivision 5.
132.29 (1) (d) If available funds are insufficient to meet county and tribal allocations under
132.30 paragraph paragraphs (a) and (b), the commissioner may make available for allocation
132.31 funds that are unobligated and available from the innovation projects through the end of
132.32 the current biennium shall proportionally prorate funds to counties and tribes that qualify
132.33 for a bonus under paragraphs (a), clause (1), and (b), clause (2).
132.34 (2) If after the application of clause (1) funds remain insufficient to meet county and
132.35 tribal allocations under paragraph (b), the commissioner must proportionally reduce the

133.1 ~~allocation of each county and tribe with respect to their maximum allocation available~~
133.2 ~~under paragraph (b).~~

133.3 Sec. 32. **[256J.78] TANF DEMONSTRATION PROJECTS OR WAIVER FROM**
133.4 **FEDERAL RULES AND REGULATIONS.**

133.5 Subdivision 1. **Duties of the commissioner.** The commissioner of human services
133.6 may pursue TANF demonstration projects or waivers of TANF requirements from the
133.7 United States Department of Health and Human Services as needed to allow the state to
133.8 build a more results-oriented Minnesota Family Investment Program to better meet the
133.9 needs of Minnesota families.

133.10 Subd. 2. **Purpose.** The purpose of the TANF demonstration projects or waivers is to:

133.11 (1) replace the federal TANF process measure and its complex administrative
133.12 requirements with state-developed outcomes measures that track adult employment and
133.13 exits from MFIP cash assistance;

133.14 (2) simplify programmatic and administrative requirements; and

133.15 (3) make other policy or programmatic changes that improve the performance of the
133.16 program and the outcomes for participants.

133.17 Subd. 3. **Report to legislature.** The commissioner shall report to the members of
133.18 the legislative committees having jurisdiction over human services issues by March 1,
133.19 2014, regarding the progress of this waiver or demonstration project.

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

133.21 Sec. 33. **[256N.001] CITATION.**

133.22 Sections 256N.001 to 256N.28 may be cited as the "Northstar Care for Children Act."
133.23 Sections 256N.001 to 256N.28 establish Northstar Care for Children, which authorizes
133.24 certain benefits to support a child in need who is served by the Minnesota child welfare
133.25 system and who is the responsibility of the state, local county social service agencies, or
133.26 tribal social service agencies authorized under section 256.01, subdivision 14b, or are
133.27 otherwise eligible for federal adoption assistance. A child eligible under this chapter
133.28 has experienced a child welfare intervention that has resulted in the child being placed
133.29 away from the child's parents' care and is receiving foster care services consistent with
133.30 chapter 260B, 260C, or 260D, or is in the permanent care of relatives through a transfer of
133.31 permanent legal and physical custody, or in the permanent care of adoptive parents.

133.32 Sec. 34. **[256N.01] PUBLIC POLICY.**

134.1 (a) The legislature declares that the public policy of this state is to keep children safe
134.2 from harm and to ensure that when children suffer harmful or injurious experiences in
134.3 their lives, appropriate services are immediately available to keep them safe.
134.4 (b) Children do best in permanent, safe, nurturing homes where they can maintain
134.5 lifelong relationships with adults. Whenever safely possible, children are best served
134.6 when they can be nurtured and raised by their parents. Where services cannot be provided
134.7 to allow a child to remain safely at home, an out-of-home placement may be required.
134.8 When this occurs, reunification should be sought if it can be accomplished safely. When
134.9 it is not possible for parents to provide safety and permanency for their children, an
134.10 alternative permanent home must quickly be made available to the child, drawing from
134.11 kinship sources whenever possible.
134.12 (c) Minnesota understands the importance of having a comprehensive approach to
134.13 temporary out-of-home care and to permanent homes for children who cannot be reunited
134.14 with their families. It is critical that stable benefits be available to caregivers to ensure
134.15 that the child's needs can be met whether the child's situation and best interests call for
134.16 temporary foster care, transfer of permanent legal and physical custody to a relative, or
134.17 adoption. Northstar Care for Children focuses on the child's needs and strengths, and
134.18 the actual level of care provided by the caregiver, without consideration for the type of
134.19 placement setting. In this way caregivers are not faced with the burden of making specific
134.20 long-term decisions based upon competing financial incentives.

134.21 Sec. 35. **[256N.02] DEFINITIONS.**
134.22 Subdivision 1. **Scope.** For the purposes of sections 256N.001 to 256N.28, the terms
134.23 defined in this section have the meanings given them.
134.24 Subd. 2. **Adoption assistance.** "Adoption assistance" means medical coverage as
134.25 allowable under section 256B.055 and reimbursement of nonrecurring expenses associated
134.26 with adoption and may include financial support provided under agreement with the
134.27 financially responsible agency, the commissioner, and the parents of an adoptive child
134.28 whose special needs would otherwise make it difficult to place the child for adoption to
134.29 assist with the cost of caring for the child. Financial support may include a basic rate
134.30 payment and a supplemental difficulty of care rate.
134.31 Subd. 3. **Assessment.** "Assessment" means the process under section 256N.24 that
134.32 determines the benefits an eligible child may receive under section 256N.26.
134.33 Subd. 4. **At-risk child.** "At-risk child" means a child who does not have a
134.34 documented disability but who is at risk of developing a physical, mental, emotional, or
134.35 behavioral disability based on being related within the first or second degree to persons

135.1 who have an inheritable physical, mental, emotional, or behavioral disabling condition,
135.2 or from a background which has the potential to cause the child to develop a physical,
135.3 mental, emotional, or behavioral disability that the child is at risk of developing. The
135.4 disability must manifest during childhood.

135.5 Subd. 5. **Basic rate.** "Basic rate" means the maintenance payment made on behalf
135.6 of a child to support the costs caregivers incur to provide for a child's needs consistent with
135.7 the care parents customarily provide, including: food, clothing, shelter, daily supervision,
135.8 school supplies, and a child's personal incidentals. It also supports typical travel to the
135.9 child's home for visitation, and reasonable travel for the child to remain in the school in
135.10 which the child is enrolled at the time of placement.

135.11 Subd. 6. **Caregiver.** "Caregiver" means the foster parent or parents of a child in
135.12 foster care who meet the requirements of emergency relative placement, licensed foster
135.13 parents under chapter 245A, or foster parents licensed or approved by a tribe; the relative
135.14 custodian or custodians; or the adoptive parent or parents who have legally adopted a child.

135.15 Subd. 7. **Commissioner.** "Commissioner" means the commissioner of human
135.16 services or any employee of the Department of Human Services to whom the
135.17 commissioner has delegated appropriate authority.

135.18 Subd. 8. **County board.** "County board" means the board of county commissioners
135.19 in each county.

135.20 Subd. 9. **Disability.** "Disability" means a physical, mental, emotional, or behavioral
135.21 impairment that substantially limits one or more major life activities. Major life activities
135.22 include, but are not limited to: thinking, walking, hearing, breathing, working, seeing,
135.23 speaking, communicating, learning, developing and maintaining healthy relationships,
135.24 safely caring for oneself, and performing manual tasks. The nature, duration, and severity
135.25 of the impairment must be considered in determining if the limitation is substantial.

135.26 Subd. 10. **Financially responsible agency.** "Financially responsible agency" means
135.27 the agency that is financially responsible for a child. These agencies include both local
135.28 social service agencies under section 393.07 and tribal social service agencies authorized
135.29 in section 256.01, subdivision 14b, as part of the American Indian Child Welfare Initiative,
135.30 and Minnesota tribes who assume financial responsibility of children from other states.
135.31 Under Northstar Care for Children, the agency that is financially responsible at the time of
135.32 placement for foster care continues to be responsible under section 256N.27 for the local
135.33 share of any maintenance payments, even after finalization of the adoption of transfer of
135.34 permanent legal and physical custody of a child.

135.35 Subd. 11. **Guardianship assistance.** "Guardianship assistance" means medical
135.36 coverage, as allowable under section 256B.055, and reimbursement of nonrecurring

136.1 expenses associated with obtaining permanent legal and physical custody of a child, and
136.2 may include financial support provided under agreement with the financially responsible
136.3 agency, the commissioner, and the relative who has received a transfer of permanent legal
136.4 and physical custody of a child. Financial support may include a basic rate payment and a
136.5 supplemental difficulty of care rate to assist with the cost of caring for the child.

136.6 Subd. 12. **Human services board.** "Human services board" means a board
136.7 established under section 402.02; Laws 1974, chapter 293; or Laws 1976, chapter 340.

136.8 Subd. 13. **Initial assessment.** "Initial assessment" means the assessment conducted
136.9 within the first 30 days of a child's initial placement into foster care under section
136.10 256N.24, subdivisions 4 and 5.

136.11 Subd. 14. **Legally responsible agency.** "Legally responsible agency" means the
136.12 Minnesota agency that is assigned responsibility for placement, care, and supervision
136.13 of the child through a court order, voluntary placement agreement, or voluntary
136.14 relinquishment. These agencies include local social service agencies under section 393.07,
136.15 tribal social service agencies authorized in section 256.01, subdivision 14b, and Minnesota
136.16 tribes that assume court jurisdiction when legal responsibility is transferred to the tribal
136.17 social service agency through a Minnesota district court order. A Minnesota local social
136.18 service agency is otherwise financially responsible.

136.19 Subd. 15. **Maintenance payments.** "Maintenance payments" means the basic
136.20 rate plus any supplemental difficulty of care rate under Northstar Care for Children. It
136.21 specifically does not include the cost of initial clothing allowance, payment for social
136.22 services, or administrative payments to a child-placing agency. Payments are paid
136.23 consistent with section 256N.26.

136.24 Subd. 16. **Permanent legal and physical custody.** "Permanent legal and physical
136.25 custody" means a transfer of permanent legal and physical custody to a relative ordered by
136.26 a Minnesota juvenile court under section 260C.515, subdivision 4, or for a child under
136.27 jurisdiction of a tribal court, a judicial determination under a similar provision in tribal
136.28 code which means that a relative will assume the duty and authority to provide care,
136.29 control, and protection of a child who is residing in foster care, and to make decisions
136.30 regarding the child's education, health care, and general welfare until adulthood.

136.31 Subd. 17. **Reassessment.** "Reassessment" means an update of a previous assessment
136.32 through the process under section 256N.24 for a child who has been continuously eligible
136.33 for Northstar Care for Children, or when a child identified as an at-risk child (Level A)
136.34 under guardianship or adoption assistance has manifested the disability upon which
136.35 eligibility for the agreement was based according to section 256N.25, subdivision 3,

137.1 paragraph (b). A reassessment may be used to update an initial assessment, a special
137.2 assessment, or a previous reassessment.

137.3 Subd. 18. **Relative.** "Relative," as described in section 260C.007, subdivision 27,
137.4 means a person related to the child by blood, marriage, or adoption, or an individual who
137.5 is an important friend with whom the child has resided or had significant contact. For an
137.6 Indian child, relative includes members of the extended family as defined by the law or
137.7 custom of the Indian child's tribe or, in the absence of law or custom, nieces, nephews,
137.8 or first or second cousins, as provided in the Indian Child Welfare Act of 1978, United
137.9 States Code, title 25, section 1903.

137.10 Subd. 19. **Relative custodian.** "Relative custodian" means a person to whom
137.11 permanent legal and physical custody of a child has been transferred under section
137.12 260C.515, subdivision 4, or for a child under jurisdiction of a tribal court, a judicial
137.13 determination under a similar provision in tribal code, which means that a relative will
137.14 assume the duty and authority to provide care, control, and protection of a child who is
137.15 residing in foster care, and to make decisions regarding the child's education, health
137.16 care, and general welfare until adulthood.

137.17 Subd. 20. **Special assessment.** "Special assessment" means an assessment
137.18 performed under section 256N.24 that determines the benefits that an eligible child may
137.19 receive under section 256N.26 at the time when a special assessment is required. A special
137.20 assessment is used in the following circumstances when a child's status within Northstar
137.21 Care is shifted from a pre-Northstar Care program into Northstar Care for Children when
137.22 the commissioner determines that a special assessment is appropriate instead of assigning
137.23 the transition child to a level under section 256N.28.

137.24 Subd. 21. **Supplemental difficulty of care rate.** "Supplemental difficulty of care
137.25 rate" means the supplemental payment under section 256N.26, if any, as determined by
137.26 the financially responsible agency or the state, based upon an assessment under section
137.27 256N.24. The rate must support activities consistent with the care a parent provides a child
137.28 with special needs and not the equivalent of a purchased service. The rate must consider
137.29 the capacity and intensity of the activities associated with parenting duties provided in
137.30 the home to nurture the child, preserve the child's connections, and support the child's
137.31 functioning in the home and community.

137.32 Sec. 36. **[256N.20] NORTHSTAR CARE FOR CHILDREN; GENERALLY.**

137.33 Subdivision 1. **Eligibility.** A child is eligible for Northstar Care for Children if
137.34 the child is eligible for:

137.35 (1) foster care under section 256N.21;

138.1 (2) guardianship assistance under section 256N.22; or
138.2 (3) adoption assistance under section 256N.23.
138.3 Subd. 2. **Assessments.** Except as otherwise specified, a child eligible for Northstar
138.4 Care for Children shall receive an assessment under section 256N.24.
138.5 Subd. 3. **Agreements.** When a child is eligible for guardianship assistance or
138.6 adoption assistance, negotiations with caregivers and the development of a written,
138.7 binding agreement must be conducted under section 256N.25.
138.8 Subd. 4. **Benefits and payments.** A child eligible for Northstar Care for Children is
138.9 entitled to benefits specified in section 256N.26, based primarily on assessments under
138.10 section 256N.24, and, if appropriate, negotiations and agreements under section 256N.25.
138.11 Although paid to the caregiver, these benefits must be considered benefits of the child
138.12 rather than of the caregiver.
138.13 Subd. 5. **Federal, state, and local shares.** The cost of Northstar Care for Children
138.14 must be shared among the federal government, state, counties of financial responsibility,
138.15 and certain tribes as specified in section 256N.27.
138.16 Subd. 6. **Administration and appeals.** The commissioner and financially
138.17 responsible agency, or other agency designated by the commissioner, shall administer
138.18 Northstar Care for Children according to section 256N.28. The notification and fair
138.19 hearing process applicable to this chapter is defined in section 256N.28.
138.20 Subd. 7. **Transition.** A child in foster care, relative custody assistance, or adoption
138.21 assistance prior to January 1, 2015, who remains with the same caregivers continues
138.22 to receive benefits under programs preceding Northstar Care for Children, unless the
138.23 child moves to a new foster care placement, permanency is obtained for the child, or the
138.24 commissioner initiates transition of a child receiving pre-Northstar Care for Children
138.25 relative custody assistance, guardianship assistance, or adoption assistance under this
138.26 chapter. Provisions for the transition to Northstar Care for Children for certain children in
138.27 preceding programs are specified in section 256N.28, subdivisions 2 and 7. Additional
138.28 provisions for children in: foster care are specified in section 256N.21, subdivision
138.29 6; relative custody assistance under section 257.85 are specified in section 256N.22,
138.30 subdivision 12; and adoption assistance under chapter 259A are specified in section
138.31 256N.23, subdivision 13.

138.32 Sec. 37. **[256N.21] ELIGIBILITY FOR FOSTER CARE BENEFITS.**
138.33 Subdivision 1. **General eligibility requirements.** (a) A child is eligible for foster
138.34 care benefits under this section if the child meets the requirements of subdivision 2 on
138.35 or after January 1, 2015.

139.1 (b) The financially responsible agency shall make a title IV-E eligibility determination
139.2 for all foster children meeting the requirements of subdivision 2, provided the agency has
139.3 such authority under the state title IV-E plan. To be eligible for title IV-E foster care, a child
139.4 must also meet any additional criteria specified in section 472 of the Social Security Act.

139.5 (c) Except as provided under section 256N.26, subdivision 1 or 6, the foster care
139.6 benefit to the child under this section must be determined under sections 256N.24 and
139.7 256N.26 through an individual assessment. Information from this assessment must be
139.8 used to determine a potential future benefit under guardianship assistance or adoption
139.9 assistance, if needed.

139.10 (d) When a child is eligible for additional services, subdivisions 3 and 4 govern
139.11 the co-occurrence of program eligibility.

139.12 Subd. 2. **Placement in foster care.** To be eligible for foster care benefits under this
139.13 section, the child must be in placement away from the child's legal parent or guardian and
139.14 all of the following criteria must be met:

139.15 (1) the legally responsible agency must have placement authority and care
139.16 responsibility, including for a child 18 years old or older and under age 21, who maintains
139.17 eligibility for foster care consistent with section 260C.451;

139.18 (2) the legally responsible agency must have authority to place the child with a
139.19 voluntary placement agreement or a court order, consistent with sections 260B.198,
139.20 260C.001, 260D.01, or continued eligibility consistent with section 260C.451; and

139.21 (3) the child must be placed in an emergency relative placement under section
139.22 245A.035, a licensed foster family setting, foster residence setting, or treatment foster
139.23 care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, a family
139.24 foster home licensed or approved by a tribal agency or, for a child 18 years old or older
139.25 and under age 21, an unlicensed supervised independent living setting approved by the
139.26 agency responsible for the youth's care.

139.27 Subd. 3. **Minor parent.** A child who is a minor parent in placement with the minor
139.28 parent's child in the same home is eligible for foster care benefits under this section. The
139.29 foster care benefit is limited to the minor parent, unless the legally responsible agency has
139.30 separate legal authority for placement of the minor parent's child.

139.31 Subd. 4. **Foster children ages 18 up to 21 placed in an unlicensed supervised**
139.32 **independent living setting.** A foster child 18 years old or older and under age 21 who
139.33 maintains eligibility consistent with section 260C.451 and who is placed in an unlicensed
139.34 supervised independent living setting shall receive the level of benefit under section
139.35 256N.26.

140.1 Subd. 5. **Excluded activities.** The basic and supplemental difficulty of care
140.2 payment represents costs for activities similar in nature to those expected of parents,
140.3 and does not cover services rendered by the licensed or tribally approved foster parent,
140.4 facility, or administrative costs or fees. The financially responsible agency may pay an
140.5 additional fee for specific services provided by the licensed foster parent or facility. A
140.6 foster parent or residence setting must distinguish such a service from the daily care of the
140.7 child as assessed through the process under section 256N.24.

140.8 Subd. 6. **Transition from pre-Northstar Care for Children program.** (a) Section
140.9 256.82 establishes the pre-Northstar Care for Children foster care program for all children
140.10 residing in family foster care on December 31, 2014. Unless transitioned under paragraph
140.11 (b), a child in foster care with the same caregiver receives benefits under this pre-Northstar
140.12 Care for Children foster care program.

140.13 (b) Transition from the pre-Northstar Care for Children foster care program to
140.14 Northstar Care for Children takes place on or after January 1, 2015, when the child:

140.15 (1) moves to a different foster home or unlicensed supervised independent living
140.16 setting;

140.17 (2) has permanent legal and physical custody transferred and, if applicable, meets
140.18 eligibility requirements in section 256N.22;

140.19 (3) is adopted and, if applicable, meets eligibility requirements in section 256N.23; or

140.20 (4) re-enters foster care after reunification or a trial home visit.

140.21 (c) Upon becoming eligible, a foster child must be assessed according to section
140.22 256N.24 and then transitioned into Northstar Care for Children according to section
140.23 256N.28.

140.24 Sec. 38. **[256N.22] GUARDIANSHIP ASSISTANCE ELIGIBILITY.**

140.25 Subdivision 1. **General eligibility requirements.** (a) To be eligible for the
140.26 guardianship assistance under this section, there must be a judicial determination under
140.27 section 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to
140.28 a relative is in the child's best interest. For a child under jurisdiction of a tribal court, a
140.29 judicial determination under a similar provision in tribal code indicating that a relative
140.30 will assume the duty and authority to provide care, control, and protection of a child who
140.31 is residing in foster care, and to make decisions regarding the child's education, health
140.32 care, and general welfare until adulthood, and that this is in the child's best interest is
140.33 considered equivalent. Additionally, a child must:

140.34 (1) have been removed from the child's home pursuant to a voluntary placement
140.35 agreement or court order;

141.1 (2)(i) have resided in foster care for at least six consecutive months in the home
141.2 of the prospective relative custodian; or
141.3 (ii) have received an exemption from the requirement in item (i) from the court
141.4 based on a determination that:
141.5 (A) an expedited move to permanency is in the child's best interest;
141.6 (B) expedited permanency cannot be completed without provision of guardianship
141.7 assistance; and
141.8 (C) the prospective relative custodian is uniquely qualified to meet the child's needs
141.9 on a permanent basis;
141.10 (3) meet the agency determinations regarding permanency requirements in
141.11 subdivision 2;
141.12 (4) meet the applicable citizenship and immigration requirements in subdivision
141.13 3; and
141.14 (5) have been consulted regarding the proposed transfer of permanent legal and
141.15 physical custody to a relative, if the child is at least 14 years of age or is expected to attain
141.16 14 years of age prior to the transfer of permanent legal and physical custody; and
141.17 (6) have a written, binding agreement under section 256N.25 among the caregiver or
141.18 caregivers, the financially responsible agency, and the commissioner established prior to
141.19 transfer of permanent legal and physical custody.
141.20 (b) In addition to the requirements in paragraph (a), the child's prospective relative
141.21 custodian or custodians must meet the applicable background study requirements in
141.22 subdivision 4.
141.23 (c) To be eligible for title IV-E guardianship assistance, a child must also meet any
141.24 additional criteria in section 473(d) of the Social Security Act. The sibling of a child
141.25 who meets the criteria for title IV-E guardianship assistance in section 473(d) of the
141.26 Social Security Act is eligible for title IV-E guardianship assistance if the child and
141.27 sibling are placed with the same prospective relative custodian or custodians, and the
141.28 legally responsible agency, relatives, and commissioner agree on the appropriateness of
141.29 the arrangement for the sibling. A child who meets all eligibility criteria except those
141.30 specific to title IV-E guardianship assistance is entitled to guardianship assistance paid
141.31 through funds other than title IV-E.
141.32 Subd. 2. **Agency determinations regarding permanency.** (a) To be eligible for
141.33 guardianship assistance, the legally responsible agency must complete the following
141.34 determinations regarding permanency for the child prior to the transfer of permanent
141.35 legal and physical custody:

142.1 (1) a determination that reunification and adoption are not appropriate permanency
142.2 options for the child; and
142.3 (2) a determination that the child demonstrates a strong attachment to the prospective
142.4 relative custodian and the prospective relative custodian has a strong commitment to
142.5 caring permanently for the child.
142.6 (b) The legally responsible agency shall document the determinations in paragraph
142.7 (a) and the supporting information for completing each determination in the case file and
142.8 make them available for review as requested by the financially responsible agency and the
142.9 commissioner during the guardianship assistance eligibility determination process.
142.10 Subd. 3. **Citizenship and immigration status.** A child must be a citizen of the
142.11 United States or otherwise be eligible for federal public benefits according to the Personal
142.12 Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order
142.13 to be eligible for guardianship assistance.
142.14 Subd. 4. **Background study.** (a) A background study under section 245C.33 must
142.15 be completed on each prospective relative custodian and any other adult residing in the
142.16 home of the prospective relative custodian. A background study on the prospective
142.17 relative custodian or adult residing in the household previously completed under section
142.18 245C.04 for the purposes of foster care licensure may be used for the purposes of this
142.19 section, provided that the background study is current at the time of the application for
142.20 guardianship assistance.
142.21 (b) If the background study reveals:
142.22 (1) a felony conviction at any time for:
142.23 (i) child abuse or neglect;
142.24 (ii) spousal abuse;
142.25 (iii) a crime against a child, including child pornography; or
142.26 (iv) a crime involving violence, including rape, sexual assault, or homicide, but not
142.27 including other physical assault or battery; or
142.28 (2) a felony conviction within the past five years for:
142.29 (i) physical assault;
142.30 (ii) battery; or
142.31 (iii) a drug-related offense;
142.32 the prospective relative custodian is prohibited from receiving guardianship assistance
142.33 on behalf of an otherwise eligible child.
142.34 Subd. 5. **Responsibility for determining guardianship assistance eligibility.** The
142.35 commissioner shall determine eligibility for:

143.1 (1) a child under the legal custody or responsibility of a Minnesota county social
143.2 service agency who would otherwise remain in foster care;
143.3 (2) a Minnesota child under tribal court jurisdiction who would otherwise remain
143.4 in foster care; and
143.5 (3) an Indian child being placed in Minnesota who meets title IV-E eligibility defined
143.6 in section 473(d) of the Social Security Act. The agency or entity assuming responsibility
143.7 for the child is responsible for the nonfederal share of the guardianship assistance payment.
143.8 Subd. 6. **Exclusions.** (a) A child with a guardianship assistance agreement under
143.9 Northstar Care for Children is not eligible for the Minnesota family investment program
143.10 child-only grant under chapter 256J.
143.11 (b) The commissioner shall not enter into a guardianship assistance agreement with:
143.12 (1) a child's biological parent;
143.13 (2) an individual assuming permanent legal and physical custody of a child or the
143.14 equivalent under tribal code without involvement of the child welfare system; or
143.15 (3) an individual assuming permanent legal and physical custody of a child who was
143.16 placed in Minnesota by another state or a tribe outside of Minnesota.
143.17 Subd. 7. **Guardianship assistance eligibility determination.** The financially
143.18 responsible agency shall prepare a guardianship assistance eligibility determination
143.19 for review and final approval by the commissioner. The eligibility determination must
143.20 be completed according to requirements and procedures and on forms prescribed by
143.21 the commissioner. Supporting documentation for the eligibility determination must be
143.22 provided to the commissioner. The financially responsible agency and the commissioner
143.23 must make every effort to establish a child's eligibility for title IV-E guardianship
143.24 assistance. A child who is determined to be eligible for guardianship assistance must
143.25 have a guardianship assistance agreement negotiated on the child's behalf according to
143.26 section 256N.25.
143.27 Subd. 8. **Termination of agreement.** (a) A guardianship assistance agreement must
143.28 be terminated in any of the following circumstances:
143.29 (1) the child has attained the age of 18, or up to age 21 when the child meets a
143.30 condition for extension in subdivision 11;
143.31 (2) the child has not attained the age of 18 years of age, but the commissioner
143.32 determines the relative custodian is no longer legally responsible for support of the child;
143.33 (3) the commissioner determines the relative custodian is no longer providing
143.34 financial support to the child up to age 21;
143.35 (4) the death of the child; or

144.1 (5) the relative custodian requests in writing termination of the guardianship
144.2 assistance agreement.
144.3 (b) A relative custodian is considered no longer legally responsible for support of
144.4 the child in any of the following circumstances:
144.5 (1) permanent legal and physical custody or guardianship of the child is transferred
144.6 to another individual;
144.7 (2) death of the relative custodian under subdivision 9;
144.8 (3) child enlists in the military;
144.9 (4) child gets married; or
144.10 (5) child is determined an emancipated minor through legal action.
144.11 Subd. 9. **Death of relative custodian or dissolution of custody.** The guardianship
144.12 assistance agreement ends upon death or dissolution of permanent legal and physical
144.13 custody of both relative custodians in the case of assignment of custody to two individuals,
144.14 or the sole relative custodian in the case of assignment of custody to one individual.
144.15 Guardianship assistance eligibility may be continued according to subdivision 10.
144.16 Subd. 10. **Assigning a child's guardianship assistance to a court-appointed**
144.17 **guardian or custodian.** (a) Guardianship assistance may be continued with the written
144.18 consent of the commissioner to an individual who is a guardian or custodian appointed by
144.19 a court for the child upon the death of both relative custodians in the case of assignment
144.20 of custody to two individuals, or the sole relative custodian in the case of assignment
144.21 of custody to one individual, unless the child is under the custody of a county, tribal,
144.22 or child-placing agency.
144.23 (b) Temporary assignment of guardianship assistance may be approved for a
144.24 maximum of six consecutive months from the death of the relative custodian or custodians
144.25 as provided in paragraph (a) and must adhere to the policies and procedures prescribed by
144.26 the commissioner. If a court has not appointed a permanent legal guardian or custodian
144.27 within six months, the guardianship assistance must terminate and must not be resumed.
144.28 (c) Upon assignment of assistance payments under this subdivision, assistance must
144.29 be provided from funds other than title IV-E.
144.30 Subd. 11. **Extension of guardianship assistance after age 18.** (a) Under the
144.31 circumstances outlined in paragraph (e), a child may qualify for extension of the
144.32 guardianship assistance agreement beyond the date the child attains age 18, up to the
144.33 date the child attains the age of 21.
144.34 (b) A request for extension of the guardianship assistance agreement must be
144.35 completed in writing and submitted, including all supporting documentation, by the

145.1 relative custodian to the commissioner at least 60 calendar days prior to the date that the
145.2 current agreement will terminate.

145.3 (c) A signed amendment to the current guardianship assistance agreement must be
145.4 fully executed between the relative custodian and the commissioner at least ten business
145.5 days prior to the termination of the current agreement. The request for extension and
145.6 the fully executed amendment must be made according to requirements and procedures
145.7 prescribed by the commissioner, including documentation of eligibility, and on forms
145.8 prescribed by the commissioner.

145.9 (d) If an agency is certifying a child for guardianship assistance and the child will
145.10 attain the age of 18 within 60 calendar days of submission, the request for extension must
145.11 be completed in writing and submitted, including all supporting documentation, with
145.12 the guardianship assistance application.

145.13 (e) A child who has attained the age of 16 prior to the effective date of the
145.14 guardianship assistance agreement is eligible for extension of the agreement up to the
145.15 date the child attains age 21 if the child:

145.16 (1) is dependent on the relative custodian for care and financial support; and

145.17 (2) meets at least one of the following conditions:

145.18 (i) is completing a secondary education program or a program leading to an
145.19 equivalent credential;

145.20 (ii) is enrolled in an institution which provides postsecondary or vocational education;

145.21 (iii) is participating in a program or activity designed to promote or remove barriers
145.22 to employment;

145.23 (iv) is employed for at least 80 hours per month; or

145.24 (v) is incapable of doing any of the activities described in items (i) to (iv) due to
145.25 a medical condition where incapability is supported by professional documentation
145.26 according to the requirements and procedures prescribed by the commissioner.

145.27 (f) A child who has not attained the age of 16 prior to the effective date of the
145.28 guardianship assistance agreement is eligible for extension of the guardianship assistance
145.29 agreement up to the date the child attains the age of 21 if the child is:

145.30 (1) dependent on the relative custodian for care and financial support; and

145.31 (2) possesses a physical or mental disability which impairs the capacity for
145.32 independent living and warrants continuation of financial assistance, as determined by
145.33 the commissioner.

145.34 Subd. 12. **Beginning guardianship assistance component of Northstar Care for**
145.35 **Children.** Effective November 27, 2014, a child who meets the eligibility criteria for
145.36 guardianship assistance in subdivision 1 may have a guardianship assistance agreement

146.1 negotiated on the child's behalf according to section 256N.25. The effective date of the
146.2 agreement must be January 1, 2015, or the date of the court order transferring permanent
146.3 legal and physical custody, whichever is later. Except as provided under section 256N.26,
146.4 subdivision 1, paragraph (c), the rate schedule for an agreement under this subdivision
146.5 is determined under section 256N.26 based on the age of the child on the date that the
146.6 prospective relative custodian signs the agreement.

146.7 Subd. 13. **Transition to guardianship assistance under Northstar Care for**
146.8 **Children.** The commissioner may execute guardianship assistance agreements for a child
146.9 with a relative custody agreement under section 257.85 executed on the child's behalf
146.10 on or before November 26, 2014, in accordance with the priorities outlined in section
146.11 256N.28, subdivision 7, paragraph (b). To facilitate transition into the guardianship
146.12 assistance program, the commissioner may waive any guardianship assistance eligibility
146.13 requirements for a child with a relative custody agreement under section 257.85 executed
146.14 on the child's behalf on or before November 26, 2014. Agreements negotiated under
146.15 this subdivision must be done according to the process outlined in section 256N.28,
146.16 subdivision 7. The maximum rate used in the negotiation process for an agreement under
146.17 this subdivision must be as outlined in section 256N.28, subdivision 7.

146.18 Sec. 39. **[256N.23] ADOPTION ASSISTANCE ELIGIBILITY.**

146.19 Subdivision 1. **General eligibility requirements.** (a) To be eligible for adoption
146.20 assistance under this section, a child must:

146.21 (1) be determined to be a child with special needs under subdivision 2;

146.22 (2) meet the applicable citizenship and immigration requirements in subdivision 3;

146.23 (3)(i) meet the criteria in section 473 of the Social Security Act; or

146.24 (ii) have had foster care payments paid on the child's behalf while in out-of-home
146.25 placement through the county or tribe and be either under the guardianship of the
146.26 commissioner or under the jurisdiction of a Minnesota tribe and adoption, according to
146.27 tribal law, is in the child's documented permanency plan; and

146.28 (4) have a written, binding agreement under section 256N.25 among the adoptive
146.29 parent, the financially responsible agency, or if there is no financially responsible agency,
146.30 the agency designated by the commissioner, and the commissioner established prior to
146.31 finalization of the adoption.

146.32 (b) In addition to the requirements in paragraph (a), an eligible child's adoptive parent
146.33 or parents must meet the applicable background study requirements in subdivision 4.

146.34 (c) A child who meets all eligibility criteria except those specific to title IV-E adoption
146.35 assistance shall receive adoption assistance paid through funds other than title IV-E.

147.1 Subd. 2. **Special needs determination.** (a) A child is considered a child with
147.2 special needs under this section if the requirements in paragraphs (b) to (g) are met.
147.3 (b) There must be a determination that the child must not or should not be returned
147.4 to the home of the child's parents as evidenced by:
147.5 (1) a court-ordered termination of parental rights;
147.6 (2) a petition to terminate parental rights;
147.7 (3) consent of parent to adoption accepted by the court under chapter 260C;
147.8 (4) in circumstances when tribal law permits the child to be adopted without a
147.9 termination of parental rights, a judicial determination by a tribal court indicating the valid
147.10 reason why the child cannot or should not return home;
147.11 (5) a voluntary relinquishment under section 259.25 or 259.47 or, if relinquishment
147.12 occurred in another state, the applicable laws in that state; or
147.13 (6) the death of the legal parent or parents if the child has two legal parents.
147.14 (c) There exists a specific factor or condition of which it is reasonable to conclude
147.15 that the child cannot be placed with adoptive parents without providing adoption
147.16 assistance as evidenced by:
147.17 (1) a determination by the Social Security Administration that the child meets all
147.18 medical or disability requirements of title XVI of the Social Security Act with respect to
147.19 eligibility for Supplemental Security Income benefits;
147.20 (2) a documented physical, mental, emotional, or behavioral disability not covered
147.21 under clause (1);
147.22 (3) a member of a sibling group being adopted at the same time by the same parent;
147.23 (4) an adoptive placement in the home of a parent who previously adopted a sibling
147.24 for whom they receive adoption assistance; or
147.25 (5) documentation that the child is an at-risk child.
147.26 (d) A reasonable but unsuccessful effort must have been made to place the child
147.27 with adoptive parents without providing adoption assistance as evidenced by:
147.28 (1) a documented search for an appropriate adoptive placement; or
147.29 (2) a determination by the commissioner that a search under clause (1) is not in the
147.30 best interests of the child.
147.31 (e) The requirement for a documented search for an appropriate adoptive placement
147.32 under paragraph (d), including the registration of the child with the state adoption
147.33 exchange and other recruitment methods under paragraph (f), must be waived if:
147.34 (1) the child is being adopted by a relative and it is determined by the child-placing
147.35 agency that adoption by the relative is in the best interests of the child;

148.1 (2) the child is being adopted by a foster parent with whom the child has developed
148.2 significant emotional ties while in the foster parent's care as a foster child and it is
148.3 determined by the child-placing agency that adoption by the foster parent is in the best
148.4 interests of the child; or
148.5 (3) the child is being adopted by a parent that previously adopted a sibling of the
148.6 child, and it is determined by the child-placing agency that adoption by this parent is
148.7 in the best interests of the child.
148.8 For an Indian child covered by the Indian Child Welfare Act, a waiver must not be
148.9 granted unless the child-placing agency has complied with the placement preferences
148.10 required by the Indian Child Welfare Act, United States Code, title 25, section 1915(a).
148.11 (f) To meet the requirement of a documented search for an appropriate adoptive
148.12 placement under paragraph (d), clause (1), the child-placing agency minimally must:
148.13 (1) conduct a relative search as required by section 260C.221 and give consideration
148.14 to placement with a relative, as required by section 260C.212, subdivision 2;
148.15 (2) comply with the placement preferences required by the Indian Child Welfare Act
148.16 when the Indian Child Welfare Act, United States Code, title 25, section 1915(a), applies;
148.17 (3) locate prospective adoptive families by registering the child on the state adoption
148.18 exchange, as required under section 259.75; and
148.19 (4) if registration with the state adoption exchange does not result in the identification
148.20 of an appropriate adoptive placement, the agency must employ additional recruitment
148.21 methods prescribed by the commissioner.
148.22 (g) Once the legally responsible agency has determined that placement with an
148.23 identified parent is in the child's best interests and made full written disclosure about the
148.24 child's social and medical history, the agency must ask the prospective adoptive parent if
148.25 the prospective adoptive parent is willing to adopt the child without receiving adoption
148.26 assistance under this section. If the identified parent is either unwilling or unable to
148.27 adopt the child without adoption assistance, the legally responsible agency must provide
148.28 documentation as prescribed by the commissioner to fulfill the requirement to make a
148.29 reasonable effort to place the child without adoption assistance. If the identified parent is
148.30 willing to adopt the child without adoption assistance, the parent must provide a written
148.31 statement to this effect to the legally responsible agency and the statement must be
148.32 maintained in the permanent adoption record of the legally responsible agency. For children
148.33 under guardianship of the commissioner, the legally responsible agency shall submit a copy
148.34 of this statement to the commissioner to be maintained in the permanent adoption record.
148.35 Subd. 3. **Citizenship and immigration status.** (a) A child must be a citizen of the
148.36 United States or otherwise eligible for federal public benefits according to the Personal

149.1 Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to
149.2 be eligible for the title IV-E adoption assistance program.
149.3 (b) A child must be a citizen of the United States or meet the qualified alien
149.4 requirements as defined in the Personal Responsibility and Work Opportunity
149.5 Reconciliation Act of 1996, as amended, in order to be eligible for adoption assistance
149.6 paid through funds other than title IV-E.
149.7 Subd. 4. **Background study.** A background study under section 259.41 must be
149.8 completed on each prospective adoptive parent. If the background study reveals:
149.9 (1) a felony conviction at any time for:
149.10 (i) child abuse or neglect;
149.11 (ii) spousal abuse;
149.12 (iii) a crime against a child, including child pornography; or
149.13 (iv) a crime involving violence, including rape, sexual assault, or homicide, but not
149.14 including other physical assault or battery; or
149.15 (2) a felony conviction within the past five years for:
149.16 (i) physical assault;
149.17 (ii) battery; or
149.18 (iii) a drug-related offense;
149.19 the adoptive parent is prohibited from receiving adoption assistance on behalf of an
149.20 otherwise eligible child.
149.21 Subd. 5. **Responsibility for determining adoption assistance eligibility.** The
149.22 commissioner must determine eligibility for:
149.23 (1) a child under the guardianship of the commissioner who would otherwise remain
149.24 in foster care;
149.25 (2) a child who is not under the guardianship of the commissioner who meets title
149.26 IV-E eligibility defined in section 473 of the Social Security Act and no state agency has
149.27 legal responsibility for placement and care of the child;
149.28 (3) a Minnesota child under tribal jurisdiction who would otherwise remain in foster
149.29 care; and
149.30 (4) an Indian child being placed in Minnesota who meets title IV-E eligibility defined
149.31 in section 473 of the Social Security Act. The agency or entity assuming responsibility for
149.32 the child is responsible for the nonfederal share of the adoption assistance payment.
149.33 Subd. 6. **Exclusions.** The commissioner must not enter into an adoption assistance
149.34 agreement with the following individuals:
149.35 (1) a child's biological parent or stepparent;

150.1 (2) a child's relative under section 260C.007, subdivision 27, with whom the child
150.2 resided immediately prior to child welfare involvement unless:
150.3 (i) the child was in the custody of a Minnesota county or tribal agency pursuant to
150.4 an order under chapter 260C or equivalent provisions of tribal code and the agency had
150.5 placement and care responsibility for permanency planning for the child; and
150.6 (ii) the child is under guardianship of the commissioner of human services according
150.7 to the requirements of section 260C.325, subdivision 1 or 3, or is a ward of a Minnesota
150.8 tribal court after termination of parental rights, suspension of parental rights, or a finding
150.9 by the tribal court that the child cannot safely return to the care of the parent;
150.10 (3) an individual adopting a child who is the subject of a direct adoptive placement
150.11 under section 259.47 or the equivalent in tribal code;
150.12 (4) a child's legal custodian or guardian who is now adopting the child; or
150.13 (5) an individual who is adopting a child who is not a citizen or resident of the
150.14 United States and was either adopted in another country or brought to the United States
150.15 for the purposes of adoption.
150.16 Subd. 7. **Adoption assistance eligibility determination.** (a) The financially
150.17 responsible agency shall prepare an adoption assistance eligibility determination for
150.18 review and final approval by the commissioner. When there is no financially responsible
150.19 agency, the adoption assistance eligibility determination must be completed by the
150.20 agency designated by the commissioner. The eligibility determination must be completed
150.21 according to requirements and procedures and on forms prescribed by the commissioner.
150.22 The financially responsible agency and the commissioner shall make every effort to
150.23 establish a child's eligibility for title IV-E adoption assistance. Documentation from a
150.24 qualified expert for the eligibility determination must be provided to the commissioner
150.25 to verify that a child meets the special needs criteria in subdivision 2. A child who
150.26 is determined to be eligible for adoption assistance must have an adoption assistance
150.27 agreement negotiated on the child's behalf according to section 256N.25.
150.28 (b) Documentation from a qualified expert of a disability is limited to evidence
150.29 deemed appropriate by the commissioner and must be submitted to the commissioner with
150.30 the eligibility determination. Examples of appropriate documentation include, but are not
150.31 limited to, medical records, psychological assessments, educational or early childhood
150.32 evaluations, court findings, and social and medical history.
150.33 (c) Documentation that the child is at risk of developing physical, mental, emotional,
150.34 or behavioral disabilities must be submitted according to policies and procedures
150.35 prescribed by the commissioner.

151.1 Subd. 8. **Termination of agreement.** (a) An adoption assistance agreement must
151.2 terminate in any of the following circumstances:
151.3 (1) the child has attained the age of 18, or up to age 21 when the child meets a
151.4 condition for extension in subdivision 12;
151.5 (2) the child has not attained the age of 18, but the commissioner determines the
151.6 adoptive parent is no longer legally responsible for support of the child;
151.7 (3) the commissioner determines the adoptive parent is no longer providing financial
151.8 support to the child up to age 21;
151.9 (4) the death of the child; or
151.10 (5) the adoptive parent requests in writing the termination of the adoption assistance
151.11 agreement.
151.12 (b) An adoptive parent is considered no longer legally responsible for support of the
151.13 child in any of the following circumstances:
151.14 (1) parental rights to the child are legally terminated or a court accepted the parent's
151.15 consent to adoption under chapter 260C;
151.16 (2) permanent legal and physical custody or guardianship of the child is transferred
151.17 to another individual;
151.18 (3) death of the adoptive parent under subdivision 9;
151.19 (4) the child enlists in the military;
151.20 (5) the child gets married; or
151.21 (6) the child is determined an emancipated minor through legal action.
151.22 Subd. 9. **Death of adoptive parent or adoption dissolution.** The adoption
151.23 assistance agreement ends upon death or termination of parental rights of both adoptive
151.24 parents in the case of a two-parent adoption, or the sole adoptive parent in the case of
151.25 a single-parent adoption. The child's adoption assistance eligibility may be continued
151.26 according to subdivision 10.
151.27 Subd. 10. **Continuing a child's title IV-E adoption assistance in a subsequent**
151.28 **adoption.** (a) The child maintains eligibility for title IV-E adoption assistance in a
151.29 subsequent adoption if the following criteria are met:
151.30 (1) the child is determined to be a child with special needs as outlined in subdivision
151.31 2; and
151.32 (2) the subsequent adoptive parent resides in Minnesota.
151.33 (b) If a child had a title IV-E adoption assistance agreement in effect prior to the
151.34 death of the adoptive parent or dissolution of the adoption, and the subsequent adoptive
151.35 parent resides outside of Minnesota, the commissioner is not responsible for determining
151.36 whether the child meets the definition of special needs, entering into the adoption

152.1 assistance agreement, and making any adoption assistance payments outlined in the new
152.2 agreement unless a state agency in Minnesota has responsibility for placement and care of
152.3 the child at the time of the subsequent adoption. If there is no state agency in Minnesota
152.4 that has responsibility for placement and care of the child at the time of the subsequent
152.5 adoption, the public child welfare agency in the subsequent adoptive parent's residence is
152.6 responsible for determining whether the child meets the definition of special needs and
152.7 entering into the adoption assistance agreement.

152.8 Subd. 11. **Assigning a child's adoption assistance to a court-appointed guardian**
152.9 **or custodian.** (a) State-funded adoption assistance may be continued with the written
152.10 consent of the commissioner to an individual who is a guardian appointed by a court for
152.11 the child upon the death of both the adoptive parents in the case of a two-parent adoption,
152.12 or the sole adoptive parent in the case of a single-parent adoption, unless the child is
152.13 under the custody of a state agency.

152.14 (b) Temporary assignment of adoption assistance may be approved by the
152.15 commissioner for a maximum of six consecutive months from the death of the adoptive
152.16 parent or parents under subdivision 9 and must adhere to the requirements and procedures
152.17 prescribed by the commissioner. If, within six months, the child has not been adopted by a
152.18 person agreed upon by the commissioner, or a court has not appointed a permanent legal
152.19 guardian under section 260C.325, 525.5-313, or similar law of another jurisdiction, the
152.20 adoption assistance must terminate.

152.21 (c) Upon assignment of payments under this subdivision, assistance must be from
152.22 funds other than title IV-E.

152.23 Subd. 12. **Extension of adoption assistance agreement.** (a) Under certain limited
152.24 circumstances a child may qualify for extension of the adoption assistance agreement
152.25 beyond the date the child attains age 18, up to the date the child attains the age of 21.

152.26 (b) A request for extension of the adoption assistance agreement must be completed
152.27 in writing and submitted, including all supporting documentation, by the adoptive parent
152.28 to the commissioner at least 60 calendar days prior to the date that the current agreement
152.29 will terminate.

152.30 (c) A signed amendment to the current adoption assistance agreement must be
152.31 fully executed between the adoptive parent and the commissioner at least ten business
152.32 days prior to the termination of the current agreement. The request for extension and the
152.33 fully executed amendment must be made according to the requirements and procedures
152.34 prescribed by the commissioner, including documentation of eligibility, on forms
152.35 prescribed by the commissioner.

153.1 (d) If an agency is certifying a child for adoption assistance and the child will attain
153.2 the age of 18 within 60 calendar days of submission, the request for extension must be
153.3 completed in writing and submitted, including all supporting documentation, with the
153.4 adoption assistance application.

153.5 (e) A child who has attained the age of 16 prior to the finalization of the child's
153.6 adoption is eligible for extension of the adoption assistance agreement up to the date the
153.7 child attains age 21 if the child is:

153.8 (1) dependent on the adoptive parent for care and financial support; and

153.9 (2)(i) completing a secondary education program or a program leading to an
153.10 equivalent credential;

153.11 (ii) enrolled in an institution that provides postsecondary or vocational education;

153.12 (iii) participating in a program or activity designed to promote or remove barriers to
153.13 employment;

153.14 (iv) employed for at least 80 hours per month; or

153.15 (v) incapable of doing any of the activities described in items (i) to (iv) due to
153.16 a medical condition where incapability is supported by documentation from an expert
153.17 according to the requirements and procedures prescribed by the commissioner.

153.18 (f) A child who has not attained the age of 16 prior to finalization of the child's
153.19 adoption is eligible for extension of the adoption assistance agreement up to the date the
153.20 child attains the age of 21 if the child is:

153.21 (1) dependent on the adoptive parent for care and financial support; and

153.22 (2)(i) enrolled in a secondary education program or a program leading to the
153.23 equivalent; or

153.24 (ii) possesses a physical or mental disability that impairs the capacity for independent
153.25 living and warrants continuation of financial assistance as determined by the commissioner.

153.26 Subd. 13. **Beginning adoption assistance under Northstar Care for Children.**
153.27 Effective November 27, 2014, a child who meets the eligibility criteria for adoption
153.28 assistance in subdivision 1, may have an adoption assistance agreement negotiated on
153.29 the child's behalf according to section 256N.25, and the effective date of the agreement
153.30 must be January 1, 2015, or the date of the court order finalizing the adoption, whichever
153.31 is later. Except as provided under section 256N.26, subdivision 1, paragraph (c), the
153.32 maximum rate schedule for the agreement must be determined according to section
153.33 256N.26 based on the age of the child on the date that the prospective adoptive parent or
153.34 parents sign the agreement.

153.35 Subd. 14. **Transition to adoption assistance under Northstar Care for Children.**
153.36 The commissioner may offer adoption assistance agreements under this chapter to a

154.1 child with an adoption assistance agreement under chapter 259A executed on the child's
154.2 behalf on or before November 26, 2014, according to the priorities outlined in section
154.3 256N.28, subdivision 7, paragraph (b). To facilitate transition into the Northstar Care for
154.4 Children adoption assistance program, the commissioner has the authority to waive any
154.5 Northstar Care for Children adoption assistance eligibility requirements for a child with
154.6 an adoption assistance agreement under chapter 259A executed on the child's behalf on
154.7 or before November 26, 2014. Agreements negotiated under this subdivision must be in
154.8 accordance with the process in section 256N.28, subdivision 7. The maximum rate used in
154.9 the negotiation process for an agreement under this subdivision must be as outlined in
154.10 section 256N.28, subdivision 7.

154.11 Sec. 40. **[256N.24] ASSESSMENTS.**

154.12 Subdivision 1. **Assessment.** (a) Each child eligible under sections 256N.21,
154.13 256N.22, and 256N.23, must be assessed to determine the benefits the child may receive
154.14 under section 256N.26, in accordance with the assessment tool, process, and requirements
154.15 specified in subdivision 2.

154.16 (b) If an agency applies the emergency foster care rate for initial placement under
154.17 section 256N.26, the agency may wait up to 30 days to complete the initial assessment.

154.18 (c) Unless otherwise specified in paragraph (d), a child must be assessed at the basic
154.19 level, level B, or one of ten supplemental difficulty of care levels, levels C to L.

154.20 (d) An assessment must not be completed for:

154.21 (1) a child eligible for guardianship assistance under section 256N.22 or adoption
154.22 assistance under section 256N.23 who is determined to be an at-risk child. A child under
154.23 this clause must be assigned level A under section 256N.26, subdivision 1; and

154.24 (2) a child transitioning into Northstar Care for Children under section 256N.28,
154.25 subdivision 7, unless the commissioner determines an assessment is appropriate.

154.26 Subd. 2. **Establishment of assessment tool, process, and requirements.** Consistent
154.27 with sections 256N.001 to 256N.28, the commissioner shall establish an assessment tool
154.28 to determine the basic and supplemental difficulty of care, and shall establish the process
154.29 to be followed and other requirements, including appropriate documentation, when
154.30 conducting the initial assessment of a child entering Northstar Care for Children or when
154.31 the special assessment and reassessments may be needed for children continuing in the
154.32 program. The assessment tool must take into consideration the strengths and needs of the
154.33 child and the extra parenting provided by the caregiver to meet the child's needs.

155.1 Subd. 3. **Child care allowance portion of assessment.** (a) The assessment tool
155.2 established under subdivision 2 must include consideration of the caregiver's need for
155.3 child care under this subdivision, with greater consideration for children of younger ages.
155.4 (b) The child's assessment must include consideration of the caregiver's need for
155.5 child care if the following criteria are met:
155.6 (1) the child is under age 13;
155.7 (2) all available adult caregivers are employed or attending educational or vocational
155.8 training programs;
155.9 (3) the caregiver does not receive child care assistance for the child under chapter
155.10 119B.
155.11 (c) For children younger than seven years of age, the level determined by the
155.12 non-child care portions of the assessment must be adjusted based on the average number
155.13 of hours child care is needed each week due to employment or attending a training or
155.14 educational program as follows:
155.15 (1) fewer than ten hours or if the caregiver is participating in the child care assistance
155.16 program under chapter 119B, no adjustment;
155.17 (2) ten to 19 hours or if needed during school summer vacation or equivalent only,
155.18 increase one level;
155.19 (3) 20 to 29 hours, increase two levels;
155.20 (4) 30 to 39 hours, increase three levels; and
155.21 (5) 40 or more hours, increase four levels.
155.22 (d) For children at least seven years of age but younger than 13, the level determined
155.23 by the non-child care portions of the assessment must be adjusted based on the average
155.24 number of hours child care is needed each week due to employment or attending a training
155.25 or educational program as follows:
155.26 (1) fewer than 20 hours, needed during school summer vacation or equivalent only,
155.27 or if the caregiver is participating in the child care assistance program under chapter
155.28 119B, no adjustment;
155.29 (2) 20 to 39 hours, increase one level; and
155.30 (3) 40 or more hours, increase two levels.
155.31 (e) When the child attains the age of seven, the child care allowance must be reduced
155.32 by reducing the level to that available under paragraph (d). For children in foster care,
155.33 benefits under section 256N.26 must be automatically reduced when the child turns seven.
155.34 For children who receive guardianship assistance or adoption assistance, agreements must
155.35 include similar provisions to ensure that the benefit provided to these children does not
155.36 exceed the benefit provided to children in foster care.

156.1 (f) When the child attains the age of 13, the child care allowance must be eliminated
156.2 by reducing the level to that available prior to any consideration of the caregiver's need
156.3 for child care. For children in foster care, benefits under section 256N.26 must be
156.4 automatically reduced when the child attains the age of 13. For children who receive
156.5 guardianship assistance or adoption assistance, agreements must include similar provisions
156.6 to ensure that the benefit provided to these children does not exceed the benefit provided
156.7 to children in foster care.

156.8 (g) The child care allowance under this subdivision is not available to caregivers
156.9 who receive the child care assistance under chapter 119B. A caregiver receiving a child
156.10 care allowance under this subdivision must notify the commissioner if the caregiver
156.11 subsequently receives the child care assistance program under chapter 119B, and the
156.12 level must be reduced to that available prior to any consideration of the caregiver's need
156.13 for child care.

156.14 (h) In establishing the assessment tool under subdivision 2, the commissioner must
156.15 design the tool so that the levels applicable to the non-child care portions of the assessment
156.16 at a given age accommodate the requirements of this subdivision.

156.17 Subd. 4. **Timing of initial assessment.** For a child entering Northstar Care for
156.18 Children under section 256N.21, the initial assessment must be completed within 30
156.19 days after the child is placed in foster care.

156.20 Subd. 5. **Completion of initial assessment.** (a) The assessment must be completed
156.21 in consultation with the child's caregiver. Face-to-face contact with the caregiver is not
156.22 required to complete the assessment.

156.23 (b) Initial assessments are completed for foster children, eligible under section
156.24 256N.21.

156.25 (c) The initial assessment must be completed by the financially responsible agency,
156.26 in consultation with the legally responsible agency if different, within 30 days of the
156.27 child's placement in foster care.

156.28 (d) If the foster parent is unable or unwilling to cooperate with the assessment process,
156.29 the child shall be assigned the basic level, level B under section 256N.26, subdivision 3.

156.30 (e) Notice to the foster parent shall be provided as specified in subdivision 12.

156.31 Subd. 6. **Timing of special assessment.** (a) A special assessment is required as part
156.32 of the negotiation of the guardianship assistance agreement under section 256N.22 if:

156.33 (1) the child was not placed in foster care with the prospective relative custodian
156.34 or custodians prior to the negotiation of the guardianship assistance agreement under
156.35 section 256N.25; or

156.36 (2) any requirement for reassessment under subdivision 8 is met.

157.1 (b) A special assessment is required as part of the negotiation of the adoption
157.2 assistance agreement under section 256N.23 if:
157.3 (1) the child was not placed in foster care with the prospective adoptive parent
157.4 or parents prior to the negotiation of the adoption assistance agreement under section
157.5 256N.25; or
157.6 (2) any requirement for reassessment under subdivision 8 is met.
157.7 (c) A special assessment is required when a child transitions from a pre-Northstar
157.8 Care for Children program into Northstar Care for Children if the commissioner
157.9 determines that a special assessment is appropriate instead of assigning the transition child
157.10 to a level under section 256N.28.
157.11 (d) The special assessment must be completed prior to the establishment of a
157.12 guardianship assistance or adoption assistance agreement on behalf of the child.
157.13 Subd. 7. **Completing the special assessment.** (a) The special assessment must
157.14 be completed in consultation with the child's caregiver. Face-to-face contact with the
157.15 caregiver is not required to complete the special assessment.
157.16 (b) If a new special assessment is required prior to the effective date of the
157.17 guardianship assistance agreement, it must be completed by the financially responsible
157.18 agency, in consultation with the legally responsible agency if different. If the prospective
157.19 relative custodian is unable or unwilling to cooperate with the special assessment process,
157.20 the child shall be assigned the basic level, level B under section 256N.26, subdivision 3,
157.21 unless the child is known to be an at-risk child, in which case, the child shall be assigned
157.22 level A under section 256N.26, subdivision 1.
157.23 (c) If a special assessment is required prior to the effective date of the adoption
157.24 assistance agreement, it must be completed by the financially responsible agency, in
157.25 consultation with the legally responsible agency if different. If there is no financially
157.26 responsible agency, the special assessment must be completed by the agency designated by
157.27 the commissioner. If the prospective adoptive parent is unable or unwilling to cooperate
157.28 with the special assessment process, the child must be assigned the basic level, level B
157.29 under section 256N.26, subdivision 3, unless the child is known to be an at-risk child, in
157.30 which case, the child shall be assigned level A under section 256N.26, subdivision 1.
157.31 (d) Notice to the prospective relative custodians or prospective adoptive parents
157.32 must be provided as specified in subdivision 12.
157.33 Subd. 8. **Timing of and requests for reassessments.** Reassessments for an eligible
157.34 child must be completed within 30 days of any of the following events:
157.35 (1) for a child in continuous foster care, when six months have elapsed since
157.36 completion of the last assessment;

158.1 (2) for a child in continuous foster care, change of placement location;

158.2 (3) for a child in foster care, at the request of the financially responsible agency or
158.3 legally responsible agency;

158.4 (4) at the request of the commissioner; or

158.5 (5) at the request of the caregiver under subdivision 9.

158.6 Subd. 9. **Caregiver requests for reassessments.** (a) A caregiver may initiate
158.7 a reassessment request for an eligible child in writing to the financially responsible
158.8 agency or, if there is no financially responsible agency, the agency designated by the
158.9 commissioner. The written request must include the reason for the request and the
158.10 name, address, and contact information of the caregivers. For an eligible child with a
158.11 guardianship assistance or adoption assistance agreement, the caregiver may request a
158.12 reassessment if at least six months have elapsed since any previously requested review.
158.13 For an eligible foster child, a foster parent may request reassessment in less than six
158.14 months with written documentation that there have been significant changes in the child's
158.15 needs that necessitate an earlier reassessment.

158.16 (b) A caregiver may request a reassessment of an at-risk child for whom a
158.17 guardianship assistance or adoption assistance agreement has been executed if the
158.18 caregiver has satisfied the commissioner with written documentation from a qualified
158.19 expert that the potential disability upon which eligibility for the agreement was based has
158.20 manifested itself, consistent with section 256N.25, subdivision 3, paragraph (b).

158.21 (c) If the reassessment cannot be completed within 30 days of the caregiver's request,
158.22 the agency responsible for reassessment must notify the caregiver of the reason for the
158.23 delay and a reasonable estimate of when the reassessment can be completed.

158.24 Subd. 10. **Completion of reassessment.** (a) The reassessment must be completed
158.25 in consultation with the child's caregiver. Face-to-face contact with the caregiver is not
158.26 required to complete the reassessment.

158.27 (b) For foster children eligible under section 256N.21, reassessments must be
158.28 completed by the financially responsible agency, in consultation with the legally
158.29 responsible agency if different.

158.30 (c) If reassessment is required after the effective date of the guardianship assistance
158.31 agreement, the reassessment must be completed by the financially responsible agency.

158.32 (d) If a reassessment is required after the effective date of the adoption assistance
158.33 agreement, it must be completed by the financially responsible agency or, if there is no
158.34 financially responsible agency, the agency designated by the commissioner.

158.35 (e) If the child's caregiver is unable or unwilling to cooperate with the reassessment,
158.36 the child must be assessed at level B under section 256N.26, subdivision 3, unless the

159.1 child has an adoption assistance or guardianship assistance agreement in place and is
159.2 known to be an at-risk child, in which case the child must be assessed at level A under
159.3 section 256N.26, subdivision 1.

159.4 Subd. 11. **Approval of initial assessments, special assessments, and**
159.5 **reassessments.** (a) Any agency completing initial assessments, special assessments, or
159.6 reassessments must designate one or more supervisors or other staff to examine and approve
159.7 assessments completed by others in the agency under subdivision 2. The person approving
159.8 an assessment must not be the case manager or staff member completing that assessment.

159.9 (b) In cases where a special assessment or reassessment for guardian assistance
159.10 and adoption assistance is required under subdivision 7 or 10, the commissioner shall
159.11 review and approve the assessment as part of the eligibility determination process outlined
159.12 in section 256N.22, subdivision 7, for guardianship assistance, or section 256N.23,
159.13 subdivision 7, for adoption assistance. The assessment determines the maximum for the
159.14 negotiated agreement amount under section 256N.25.

159.15 (c) The new rate is effective the calendar month that the assessment is approved,
159.16 or the effective date of the agreement, whichever is later.

159.17 Subd. 12. **Notice for caregiver.** (a) The agency as defined in subdivision 5 or 10
159.18 that is responsible for completing the initial assessment or reassessment must provide the
159.19 child's caregiver with written notice of the initial assessment or reassessment.

159.20 (b) Initial assessment notices must be sent within 15 days of completion of the initial
159.21 assessment and must minimally include the following:

159.22 (1) a summary of the child's completed individual assessment used to determine the
159.23 initial rating;

159.24 (2) statement of rating and benefit level;

159.25 (3) statement of the circumstances under which the agency must reassess the child;

159.26 (4) procedure to seek reassessment;

159.27 (5) notice that the caregiver has the right to a fair hearing review of the assessment
159.28 and how to request a fair hearing, consistent with section 256.045, subdivision 3; and

159.29 (6) the name, telephone number, and e-mail, if available, of a contact person at the
159.30 agency completing the assessment.

159.31 (c) Reassessment notices must be sent within 15 days after the completion of the
159.32 reassessment and must minimally include the following:

159.33 (1) a summary of the child's individual assessment used to determine the new rating;

159.34 (2) any change in rating and its effective date;

159.35 (3) procedure to seek reassessment;

160.1 (4) notice that if a change in rating results in a reduction of benefits, the caregiver
160.2 has the right to a fair hearing review of the assessment and how to request a fair hearing
160.3 consistent with section 256.045, subdivision 3;

160.4 (5) notice that a caregiver who requests a fair hearing of the reassessed rating within
160.5 ten days may continue at the current rate pending the hearing, but the agency may recover
160.6 any overpayment; and

160.7 (6) name, telephone number, and e-mail, if available, of a contact person at the
160.8 agency completing the reassessment.

160.9 (d) Notice is not required for special assessments since the notice is part of the
160.10 guardianship assistance or adoption assistance negotiated agreement completed according
160.11 to section 256N.25.

160.12 Subd. 13. **Assessment tool determines rate of benefits.** The assessment tool
160.13 established by the commissioner in subdivision 2 determines the monthly benefit level
160.14 for children in foster care. The monthly payment for guardian assistance or adoption
160.15 assistance may be negotiated up to the monthly benefit level under foster care for those
160.16 children eligible for a payment under section 256N.26, subdivision 1.

160.17 Sec. 41. **[256N.25] AGREEMENTS.**

160.18 Subdivision 1. **Agreement; guardianship assistance; adoption assistance.** (a)
160.19 In order to receive guardianship assistance or adoption assistance benefits on behalf of
160.20 an eligible child, a written, binding agreement between the caregiver or caregivers, the
160.21 financially responsible agency, or, if there is no financially responsible agency, the agency
160.22 designated by the commissioner, and the commissioner must be established prior to
160.23 finalization of the adoption or a transfer of permanent legal and physical custody. The
160.24 agreement must be negotiated with the caregiver or caregivers under subdivision 2.

160.25 (b) The agreement must be on a form approved by the commissioner and must
160.26 specify the following:

160.27 (1) duration of the agreement;

160.28 (2) the nature and amount of any payment, services, and assistance to be provided
160.29 under such agreement;

160.30 (3) the child's eligibility for Medicaid services;

160.31 (4) the terms of the payment, including any child care portion as specified in section
160.32 256N.24, subdivision 3;

160.33 (5) eligibility for reimbursement of nonrecurring expenses associated with adopting
160.34 or obtaining permanent legal and physical custody of the child, to the extent that the
160.35 total cost does not exceed $2,000 per child;

161.1 (6) that the agreement must remain in effect regardless of the state of which the
161.2 adoptive parents or relative custodians are residents at any given time;
161.3 (7) provisions for modification of the terms of the agreement, including renegotiation
161.4 of the agreement; and
161.5 (8) the effective date of the agreement.
161.6 (c) The caregivers, the commissioner, and the financially responsible agency, or, if
161.7 there is no financially responsible agency, the agency designated by the commissioner, must
161.8 sign the agreement. A copy of the signed agreement must be given to each party. Once
161.9 signed by all parties, the commissioner shall maintain the official record of the agreement.
161.10 (d) The effective date of the guardianship assistance agreement must be the date of the
161.11 court order that transfers permanent legal and physical custody to the relative. The effective
161.12 date of the adoption assistance agreement is the date of the finalized adoption decree.
161.13 (e) Termination or disruption of the preadoptive placement or the foster care
161.14 placement prior to assignment of custody makes the agreement with that caregiver void.
161.15 Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible
161.16 for guardianship assistance or adoption assistance, the financially responsible agency, or,
161.17 if there is no financially responsible agency, the agency designated by the commissioner,
161.18 must negotiate with the caregiver to develop an agreement under subdivision 1. If and when
161.19 the caregiver and agency reach concurrence as to the terms of the agreement, both parties
161.20 shall sign the agreement. The agency must submit the agreement, along with the eligibility
161.21 determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to
161.22 the commissioner for final review, approval, and signature according to subdivision 1.
161.23 (b) A monthly payment is provided as part of the adoption assistance or guardianship
161.24 assistance agreement to support the care of children unless the child is determined to be an
161.25 at-risk child, in which case the special at-risk monthly payment under section 256N.26,
161.26 subdivision 7, must be made until the caregiver obtains written documentation from a
161.27 qualified expert that the potential disability upon which eligibility for the agreement
161.28 was based has manifested itself.
161.29 (1) The amount of the payment made on behalf of a child eligible for guardianship
161.30 assistance or adoption assistance is determined through agreement between the prospective
161.31 relative custodian or the adoptive parent and the financially responsible agency, or, if there
161.32 is no financially responsible agency, the agency designated by the commissioner, using
161.33 the assessment tool established by the commissioner in section 256N.24, subdivision 2,
161.34 and the associated benefit and payments outlined in section 256N.26. Except as provided
161.35 under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes
161.36 the monthly benefit level for a child under foster care. The monthly payment under a

162.1 guardianship assistance agreement or adoption assistance agreement may be negotiated up
162.2 to the monthly benefit level under foster care. In no case may the amount of the payment
162.3 under a guardianship assistance agreement or adoption assistance agreement exceed the
162.4 foster care maintenance payment which would have been paid during the month if the
162.5 child with respect to whom the guardianship assistance or adoption assistance payment is
162.6 made had been in a foster family home in the state.

162.7 (2) The rate schedule for the agreement is determined based on the age of the
162.8 child on the date that the prospective adoptive parent or parents or relative custodian or
162.9 custodians sign the agreement.

162.10 (3) The income of the relative custodian or custodians or adoptive parent or parents
162.11 must not be taken into consideration when determining eligibility for guardianship
162.12 assistance or adoption assistance or the amount of the payments under section 256N.26.

162.13 (4) With the concurrence of the relative custodian or adoptive parent, the amount of
162.14 the payment may be adjusted periodically using the assessment tool established by the
162.15 commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under
162.16 subdivision 3 when there is a change in the child's needs or the family's circumstances.

162.17 (5) The guardianship assistance or adoption assistance agreement of a child who is
162.18 identified as at-risk receives the special at-risk monthly payment under section 256N.26,
162.19 subdivision 7, unless and until the potential disability manifests itself, as documented by
162.20 an appropriate professional, and the commissioner authorizes commencement of payment
162.21 by modifying the agreement accordingly. A relative custodian or adoptive parent of an
162.22 at-risk child with a guardianship assistance or adoption assistance agreement may request
162.23 a reassessment of the child under section 256N.24, subdivision 9, and renegotiation of
162.24 the guardianship assistance or adoption assistance agreement under subdivision 3 to
162.25 include a monthly payment, if the caregiver has written documentation from a qualified
162.26 expert that the potential disability upon which eligibility for the agreement was based has
162.27 manifested itself. Documentation of the disability must be limited to evidence deemed
162.28 appropriate by the commissioner.

162.29 (c) For guardianship assistance agreements:

162.30 (1) the initial amount of the monthly guardianship assistance payment must be
162.31 equivalent to the foster care rate in effect at the time that the agreement is signed less any
162.32 offsets under section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to
162.33 by the prospective relative custodian and specified in that agreement, unless the child is
162.34 identified as at-risk or the guardianship assistance agreement is entered into when a child
162.35 is under the age of six;

163.1 (2) an at-risk child must be assigned level A as outlined in section 256N.26 and
163.2 receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless
163.3 and until the potential disability manifests itself, as documented by a qualified expert and
163.4 the commissioner authorizes commencement of payment by modifying the agreement
163.5 accordingly; and

163.6 (3) the amount of the monthly payment for a guardianship assistance agreement for
163.7 a child, other than an at-risk child, who is under the age of six must be as specified in
163.8 section 256N.26, subdivision 5.

163.9 (d) For adoption assistance agreements:

163.10 (1) for a child in foster care with the prospective adoptive parent immediately prior
163.11 to adoptive placement, the initial amount of the monthly adoption assistance payment
163.12 must be equivalent to the foster care rate in effect at the time that the agreement is signed
163.13 less any offsets in section 256N.26, subdivision 11, or a lesser negotiated amount if agreed
163.14 to by the prospective adoptive parents and specified in that agreement, unless the child is
163.15 identified as at-risk or the adoption assistance agreement is entered into when a child is
163.16 under the age of six;

163.17 (2) an at-risk child must be assigned level A as outlined in section 256N.26 and
163.18 receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless
163.19 and until the potential disability manifests itself, as documented by an appropriate
163.20 professional and the commissioner authorizes commencement of payment by modifying
163.21 the agreement accordingly;

163.22 (3) the amount of the monthly payment for an adoption assistance agreement for
163.23 a child under the age of six, other than an at-risk child, must be as specified in section
163.24 256N.26, subdivision 5;

163.25 (4) for a child who is in the guardianship assistance program immediately prior
163.26 to adoptive placement, the initial amount of the adoption assistance payment must be
163.27 equivalent to the guardianship assistance payment in effect at the time that the adoption
163.28 assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive
163.29 parent and specified in that agreement; and

163.30 (5) for a child who is not in foster care placement or the guardianship assistance
163.31 program immediately prior to adoptive placement or negotiation of the adoption assistance
163.32 agreement, the initial amount of the adoption assistance agreement must be determined
163.33 using the assessment tool and process in this section and the corresponding payment
163.34 amount outlined in section 256N.26.

163.35 Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive parent
163.36 of a child with a guardianship assistance or adoption assistance agreement may request

164.1 renegotiation of the agreement when there is a change in the needs of the child or in the
164.2 family's circumstances. When a relative custodian or adoptive parent requests renegotiation
164.3 of the agreement, a reassessment of the child must be completed consistent with section
164.4 256N.24, subdivisions 9 and 10. If the reassessment indicates that the child's level has
164.5 changed, the financially responsible agency, or, if there is no financially responsible
164.6 agency, the agency designated by the commissioner or a designee and the caregiver must
164.7 renegotiate the agreement to include a payment with the level determined through the
164.8 reassessment process. The agreement must not be renegotiated unless the commissioner,
164.9 the financially responsible agency, and the caregiver mutually agree to the changes. The
164.10 effective date of any renegotiated agreement must be determined by the commissioner.

164.11 (b) A relative custodian or adoptive parent of an at-risk child with a guardianship
164.12 assistance or adoption assistance agreement may request renegotiation of the agreement to
164.13 include a monthly payment higher than the special at-risk monthly payment under section
164.14 256N.26, subdivision 7, if the caregiver has written documentation from a qualified
164.15 expert that the potential disability upon which eligibility for the agreement was based has
164.16 manifested itself. Documentation of the disability must be limited to evidence deemed
164.17 appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment
164.18 of the child must be conducted as outlined in section 256N.24, subdivision 9. The
164.19 reassessment must be used to renegotiate the agreement to include an appropriate monthly
164.20 payment. The agreement must not be renegotiated unless the commissioner, the financially
164.21 responsible agency, and the caregiver mutually agree to the changes. The effective date of
164.22 any renegotiated agreement must be determined by the commissioner.

164.23 (c) Renegotiation of a guardianship assistance or adoption assistance agreement is
164.24 required when one of the circumstances outlined in section 256N.26, subdivision 13,
164.25 occurs.

164.26 Sec. 42. **[256N.26] BENEFITS AND PAYMENTS.**

164.27 Subdivision 1. **Benefits.** (a) There are three benefits under Northstar Care for
164.28 Children: medical assistance, basic payment, and supplemental difficulty of care payment.

164.29 (b) A child is eligible for medical assistance under subdivision 2.

164.30 (c) A child is eligible for the basic payment under subdivision 3, except for a child
164.31 assigned level A under section 256N.24, subdivision 1, because the child is determined to
164.32 be an at-risk child receiving guardianship assistance or adoption assistance.

164.33 (d) A child, including a foster child age 18 to 21, is eligible for an additional
164.34 supplemental difficulty of care payment under subdivision 4, as determined by the
164.35 assessment under section 256N.24.

165.1 (e) An eligible child entering guardianship assistance or adoption assistance under
165.2 the age of six receives a basic payment and supplemental difficulty of care payment as
165.3 specified in subdivision 5.

165.4 (f) A child transitioning in from a pre-Northstar Care for Children program under
165.5 section 256N.28, subdivision 7, shall receive basic and difficulty of care supplemental
165.6 payments according to those provisions.

165.7 Subd. 2. **Medical assistance.** Eligibility for medical assistance under this chapter
165.8 must be determined according to section 256B.055.

165.9 Subd. 3. **Basic monthly rate.** From January 1, 2015, to June 30, 2016, the basic
165.10 monthly rate must be according to the following schedule:

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

165.14 Subd. 4. **Difficulty of care supplemental monthly rate.** From January 1, 2015,
165.15 to June 30, 2016, the supplemental difficulty of care monthly rate is determined by the
165.16 following schedule:

165.17 165.18	Level A	none (special rate under subdivision 7 applies)
165.19	Level B	none (basic under subdivision 3 only)
165.20	Level C	$100 per month
165.21	Level D	$200 per month
165.22	Level E	$300 per month
165.23	Level F	$400 per month
165.24	Level G	$500 per month
165.25	Level H	$600 per month
165.26	Level I	$700 per month
165.27	Level J	$800 per month
165.28	Level K	$900 per month
165.29	Level L	$1,000 per month

165.30 A child assigned level A is not eligible for either the basic or supplemental difficulty
165.31 of care payment, while a child assigned level B is not eligible for the supplemental
165.32 difficulty of care payment but is eligible for the basic monthly rate under subdivision 3.

165.33 Subd. 5. **Alternate rates for preschool entry and certain transitioned children.**
165.34 A child who entered the guardianship assistance or adoption assistance components
165.35 of Northstar Care for Children while under the age of six shall receive 50 percent of
165.36 the amount the child would otherwise be entitled to under subdivisions 3 and 4. The
165.37 commissioner may also use the 50 percent rate for a child who was transitioned into those
165.38 components through declaration of the commissioner under section 256N.28, subdivision 7.

166.1 Subd. 6. **Emergency foster care rate for initial placement.** (a) A child who enters
166.2 foster care due to immediate custody by a police officer or court order, consistent with
166.3 section 260C.175, subdivisions 1 and 2, or equivalent provision under tribal code, shall
166.4 receive the emergency foster care rate for up to 30 days. The emergency foster care rate
166.5 cannot be extended beyond 30 days of the child's placement.

166.6 (b) For this payment rate to be applied, at least one of three conditions must apply:

166.7 (1) the child's initial placement must be in foster care in Minnesota;

166.8 (2) the child's previous placement was more than two years ago; or

166.9 (3) the child's previous placement was for fewer than 30 days and an assessment
166.10 under section 256N.24 was not completed by an agency under section 256N.24.

166.11 (c) The emergency foster care rate consists of the appropriate basic monthly rate
166.12 under subdivision 3 plus a difficulty of care supplemental monthly rate of level D under
166.13 subdivision 4.

166.14 (d) The emergency foster care rate ends under any of three conditions:

166.15 (1) when an assessment under section 256N.24 is completed;

166.16 (2) when the placement ends; or

166.17 (3) after 30 days have elapsed.

166.18 (e) The financially responsible agency, in consultation with the legally responsible
166.19 agency, if different, may replace the emergency foster care rate at any time by completing
166.20 an initial assessment on which a revised difficulty of care supplemental monthly rate
166.21 would be based. Consistent with section 256N.24, subdivision 9, the caregiver may
166.22 request a reassessment in writing for an initial assessment to replace the emergency foster
166.23 care rate. This written request would initiate an initial assessment under section 256N.24,
166.24 subdivision 5. If the revised difficulty of care supplemental level based on the initial
166.25 assessment is higher than Level D, then the revised higher rate shall apply retroactively to
166.26 the beginning of the placement. If the revised level is lower, the lower rate shall apply on
166.27 the date the initial assessment was completed.

166.28 (f) If a child remains in foster care placement for more than 30 days, the emergency
166.29 foster care rate ends after the 30th day of placement and an assessment under section
166.30 256N.26 must be completed.

166.31 Subd. 7. **Special at-risk monthly payment for at-risk children in guardianship**
166.32 **assistance and adoption assistance.** A child eligible for guardianship assistance under
166.33 section 256N.22 or adoption assistance under section 256N.23 who is determined to be
166.34 an at-risk child shall receive a special at-risk monthly payment of $1 per month basic,
166.35 unless and until the potential disability manifests itself and the agreement is renegotiated
166.36 to include reimbursement. Such an at-risk child shall receive neither a supplemental

167.1 difficulty of care monthly rate under subdivision 4 nor home and vehicle modifications
167.2 under subdivision 10, but must be considered for medical assistance under subdivision 2.

167.3 Subd. 8. **Daily rates.** (a) The commissioner shall establish prorated daily rates to
167.4 the nearest cent for the monthly rates under subdivisions 3 to 7. Daily rates must be
167.5 routinely used when a partial month is involved for foster care, guardianship assistance, or
167.6 adoption assistance.

167.7 (b) A full month payment is permitted if a foster child is temporarily absent from
167.8 the foster home if the brief absence does not exceed 14 days and the child's placement
167.9 continues with the same caregiver.

167.10 Subd. 9. **Revision.** By April 1, 2016, for fiscal year 2017, and by each succeeding
167.11 April 1 for the subsequent fiscal year, the commissioner shall review and revise the rates
167.12 under subdivisions 3 to 7 based on the United States Department of Agriculture, Estimates
167.13 of the Cost of Raising a Child, published by the United States Department of Agriculture,
167.14 Agricultural Resources Service, Publication 1411. The revision shall be the average
167.15 percentage by which costs increase for the age ranges represented in the United States
167.16 Department of Agriculture, Estimates of the Cost of Raising a Child, except that in no
167.17 instance must the increase be more than three percent per annum. The monthly rates must
167.18 be revised to the nearest dollar and the daily rates to the nearest cent.

167.19 Subd. 10. **Home and vehicle modifications.** (a) Except for a child assigned level A
167.20 under section 256N.24, subdivision 1, paragraph (b), clause (1), a child who is eligible
167.21 for an adoption assistance agreement may have reimbursement of home and vehicle
167.22 modifications necessary to accommodate the child's special needs upon which eligibility
167.23 for adoption assistance was based and included as part of the negotiation of the agreement
167.24 under section 256N.25, subdivision 2. Reimbursement of home and vehicle modifications
167.25 must not be available for a child who is assessed at level A under subdivision 1, unless
167.26 and until the potential disability manifests itself and the agreement is renegotiated to
167.27 include reimbursement.

167.28 (b) Application for and reimbursement of modifications must be completed
167.29 according to a process specified by the commissioner. The type and cost of each
167.30 modification must be preapproved by the commissioner. The type of home and vehicle
167.31 modifications must be limited to those specified by the commissioner.

167.32 (c) Reimbursement for home modifications as outlined in this subdivision is limited
167.33 to once every five years per child. Reimbursement for vehicle modifications as outlined in
167.34 this subdivision is limited to once every five years per family.

167.35 Subd. 11. **Child income or income attributable to the child.** (a) A monthly
167.36 guardianship assistance or adoption assistance payment must be considered as income

168.1 and resource attributable to the child. Guardianship assistance and adoption assistance
168.2 are exempt from garnishment, except as permissible under the laws of the state where the
168.3 child resides.

168.4 (b) When a child is placed into foster care, any income and resources attributable
168.5 to the child are treated as provided in sections 252.27 and 260C.331, or 260B.331, as
168.6 applicable to the child being placed.

168.7 (c) Consideration of income and resources attributable to the child must be part of
168.8 the negotiation process outlined in section 256N.25, subdivision 2. In some circumstances,
168.9 the receipt of other income on behalf of the child may impact the amount of the monthly
168.10 payment received by the relative custodian or adoptive parent on behalf of the child
168.11 through Northstar Care for Children. Supplemental Security Income (SSI), retirement
168.12 survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and
168.13 black lung benefits are considered income and resources attributable to the child.

168.14 Subd. 12. **Treatment of Supplemental Security Income.** If a child placed in foster
168.15 care receives benefits through Supplemental Security Income (SSI) at the time of foster
168.16 care placement or subsequent to placement in foster care, the financially responsible
168.17 agency may apply to be the payee for the child for the duration of the child's placement in
168.18 foster care. If a child continues to be eligible for SSI after finalization of the adoption or
168.19 transfer of permanent legal and physical custody and is determined to be eligible for a
168.20 payment under Northstar Care for Children, a permanent caregiver may choose to receive
168.21 payment from both programs simultaneously. The permanent caregiver is responsible
168.22 to report the amount of the payment to the Social Security Administration and the SSI
168.23 payment will be reduced as required by Social Security.

168.24 Subd. 13. **Treatment of retirement survivor's disability insurance, veteran's**
168.25 **benefits, railroad retirement benefits, and black lung benefits.** (a) If a child placed
168.26 in foster care receives retirement survivor's disability insurance, veteran's benefits,
168.27 railroad retirement benefits, or black lung benefits at the time of foster care placement or
168.28 subsequent to placement in foster care, the financially responsible agency may apply to
168.29 be the payee for the child for the duration of the child's placement in foster care. If it is
168.30 anticipated that a child will be eligible to receive retirement survivor's disability insurance,
168.31 veteran's benefits, railroad retirement benefits, or black lung benefits after finalization
168.32 of the adoption or assignment of permanent legal and physical custody, the permanent
168.33 caregiver shall apply to be the payee of those benefits on the child's behalf. The monthly
168.34 amount of the other benefits must be considered an offset to the amount of the payment
168.35 the child is determined eligible for under Northstar Care for Children.

169.1 (b) If a child becomes eligible for retirement survivor's disability insurance, veteran's
169.2 benefits, railroad retirement benefits, or black lung benefits, after the initial amount of the
169.3 payment under Northstar Care for Children is finalized, the permanent caregiver shall
169.4 contact the commissioner to redetermine the payment under Northstar Care for Children.
169.5 The monthly amount of the other benefits must be considered an offset to the amount of
169.6 the payment the child is determined eligible for under Northstar Care for Children.
169.7 (c) If a child ceases to be eligible for retirement survivor's disability insurance,
169.8 veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount
169.9 of the payment under Northstar Care for Children is finalized, the permanent caregiver
169.10 shall contact the commissioner to redetermine the payment under Northstar Care for
169.11 Children. The monthly amount of the payment under Northstar Care for Children must be
169.12 the amount the child was determined to be eligible for prior to consideration of any offset.
169.13 (d) If the monthly payment received on behalf of the child under retirement survivor's
169.14 disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits
169.15 changes after the adoption assistance or guardianship assistance agreement is finalized,
169.16 the permanent caregiver shall notify the commissioner as to the new monthly payment
169.17 amount, regardless of the amount of the change in payment. If the monthly payment
169.18 changes by $75 or more, even if the change occurs incrementally over the duration of
169.19 the term of the adoption assistance or guardianship assistance agreement, the monthly
169.20 payment under Northstar Care for Children must be adjusted without further consent
169.21 to reflect the amount of the increase or decrease in the offset amount. Any subsequent
169.22 change to the payment must be reported and handled in the same manner. A change of
169.23 monthly payments of less than $75 is not a permissible reason to renegotiate the adoption
169.24 assistance or guardianship assistance agreement under section 256N.25, subdivision 3.
169.25 The commissioner shall review and revise the limit at which the adoption assistance or
169.26 guardian assistance agreement must be renegotiated in accordance with subdivision 9.
169.27 Subd. 14. **Treatment of child support and Minnesota family investment**
169.28 **program.** (a) If a child placed in foster care receives child support, the child support
169.29 payment may be redirected to the financially responsible agency for the duration of the
169.30 child's placement in foster care. In cases where the child qualifies for Northstar Care
169.31 for Children by meeting the adoption assistance eligibility criteria or the guardianship
169.32 assistance eligibility criteria, any court ordered child support must not be considered
169.33 income attributable to the child and must have no impact on the monthly payment.
169.34 (b) Consistent with section 256J.24, a child eligible for Northstar Care for Children
169.35 whose caregiver receives a payment on the child's behalf is excluded from a Minnesota
169.36 family investment program assistance unit.

170.1 Subd. 15. **Payments.** (a) Payments to caregivers under Northstar Care for Children
170.2 must be made monthly. Consistent with section 256N.24, subdivision 12, the financially
170.3 responsible agency must send the caregiver the required written notice within 15 days of
170.4 a completed assessment or reassessment.

170.5 (b) Unless paragraph (c) or (d) applies, the financially responsible agency shall pay
170.6 foster parents directly for eligible children in foster care.

170.7 (c) When the legally responsible agency is different than the financially responsible
170.8 agency, the legally responsible agency may make the payments to the caregiver, provided
170.9 payments are made on a timely basis. The financially responsible agency must pay
170.10 the legally responsible agency on a timely basis. Caregivers must have access to the
170.11 financially and legally responsible agencies' records of the transaction, consistent with
170.12 the retention schedule for the payments.

170.13 (d) For eligible children in foster care, the financially responsible agency may pay
170.14 the foster parent's payment for a licensed child-placing agency instead of paying the foster
170.15 parents directly. The licensed child-placing agency must timely pay the foster parents
170.16 and maintain records of the transaction. Caregivers must have access to the financially
170.17 responsible agency's records on the transaction and the child-placing agency's records of
170.18 the transaction, consistent with the retention schedule for the payments.

170.19 Subd. 16. **Effect of benefit on other aid.** Payments received under this section
170.20 must not be considered as income for child care assistance under chapter 119B or any
170.21 other financial benefit. Consistent with section 256J.24, a child receiving a maintenance
170.22 payment under Northstar Care for Children is excluded from any Minnesota family
170.23 investment program assistance unit.

170.24 Subd. 17. **Home and community-based services waiver for persons with**
170.25 **disabilities.** A child in foster care may qualify for home and community-based waivered
170.26 services, consistent with section 256B.092 for developmental disabilities, or section
170.27 256B.49 for community alternative care, community alternatives for disabled individuals,
170.28 or traumatic brain injury waivers. A waiver service must not be substituted for the foster
170.29 care program. When the child is simultaneously eligible for waivered services and for
170.30 benefits under Northstar Care for Children, the financially responsible agency must
170.31 assess and provide basic and supplemental difficulty of care rates as determined by the
170.32 assessment according to section 256N.24. If it is determined that additional services are
170.33 needed to meet the child's needs in the home that is not or cannot be met by the foster care
170.34 program, the need would be referred to the local waivered service program.

170.35 Subd. 18. **Overpayments.** The commissioner has the authority to collect any
170.36 amount of foster care payment, adoption assistance, or guardianship assistance paid

171.1 to a caregiver in excess of the payment due. Payments covered by this subdivision
171.2 include basic maintenance needs payments, supplemental difficulty of care payments, and
171.3 reimbursement of home and vehicle modifications under subdivision 10. Prior to any
171.4 collection, the commissioner or designee shall notify the caregiver in writing, including:

171.5 (1) the amount of the overpayment and an explanation of the cause of overpayment;

171.6 (2) clarification of the corrected amount;

171.7 (3) a statement of the legal authority for the decision;

171.8 (4) information about how the caregiver can correct the overpayment;

171.9 (5) if repayment is required, when the payment is due and a person to contact to
171.10 review a repayment plan;

171.11 (6) a statement that the caregiver has a right to a fair hearing review by the
171.12 department; and

171.13 (7) the procedure for seeking a fair hearing review by the department.

171.14 Subd. 19. **Payee.** For adoption assistance and guardianship assistance cases, the
171.15 payment must only be made to the adoptive parent or relative custodian specified on the
171.16 agreement. If there is more than one adoptive parent or relative custodian, both parties will
171.17 be listed as the payee unless otherwise specified in writing according to policies outlined
171.18 by the commissioner. In the event of divorce or separation of the caregivers, a change of
171.19 payee must be made in writing according to policies outlined by the commissioner. If both
171.20 caregivers are in agreement as to the change, it may be made according to a process outlined
171.21 by the commissioner. If there is not agreement as to the change, a court order indicating
171.22 the party who is to receive the payment is needed before a change can be processed. If the
171.23 change of payee is disputed, the commissioner may withhold the payment until agreement
171.24 is reached. A noncustodial caregiver may request notice in writing of review, modification,
171.25 or termination of the adoption assistance or guardianship assistance agreement. In the
171.26 event of the death of a payee, a change of payee consistent with sections 256N.22 and
171.27 256N.23 may be made in writing according to policies outlined by the commissioner.

171.28 Subd. 20. **Notification of change.** (a) A caregiver who has an adoption assistance
171.29 agreement or guardianship assistance agreement in place shall keep the agency
171.30 administering the program informed of changes in status or circumstances which would
171.31 make the child ineligible for the payments or eligible for payments in a different amount.

171.32 (b) For the duration of the agreement, the caregiver agrees to notify the agency
171.33 administering the program in writing within 30 days of any of the following:

171.34 (1) a change in the child's or caregiver's legal name;

171.35 (2) a change in the family's address;

171.36 (3) a change in the child's legal custody status;

172.1 (4) the child's completion of high school, if this occurs after the child attains age 18;
172.2 (5) the end of the caregiver's legal responsibility to support the child based on
172.3 termination of parental rights of the caregiver, transfer of guardianship to another person,
172.4 or transfer of permanent legal and physical custody to another person;
172.5 (6) the end of the caregiver's financial support of the child;
172.6 (7) the death of the child;
172.7 (8) the death of the caregiver;
172.8 (9) the child enlists in the military;
172.9 (10) the child gets married;
172.10 (11) the child becomes an emancipated minor through legal action;
172.11 (12) the caregiver separates or divorces; and
172.12 (13) the child is residing outside the caregiver's home for a period of more than
172.13 30 consecutive days.
172.14 Subd. 21. **Correct and true information.** The caregiver must be investigated for
172.15 fraud if the caregiver reports information the caregiver knows is untrue, the caregiver
172.16 fails to notify the commissioner of changes that may affect eligibility, or the agency
172.17 administering the program receives relevant information that the caregiver did not report.
172.18 Subd. 22. **Termination notice for caregiver.** The agency that issues the
172.19 maintenance payment shall provide the child's caregiver with written notice of termination
172.20 of payment. Termination notices must be sent at least 15 days before the final payment or
172.21 in the case of an unplanned termination, the notice is sent within three days of the end of
172.22 the payment. The written notice must minimally include the following:
172.23 (1) the date payment will end;
172.24 (2) the reason payments will end and the event that is the basis to terminate payment;
172.25 (3) a statement that the provider has a right to a fair hearing review by the department
172.26 consistent with section 256.045, subdivision 3;
172.27 (4) the procedure to request a fair hearing; and
172.28 (5) name, telephone number, and email address of a contact person at the agency.

172.29 Sec. 43. **[256N.27] FEDERAL, STATE, AND LOCAL SHARES.**
172.30 Subdivision 1. **Federal share.** For the purposes of determining a child's eligibility
172.31 under title IV-E of the Social Security Act for a child in foster care, the financially
172.32 responsible agency shall use the eligibility requirements outlined in section 472 of the
172.33 Social Security Act. For a child who qualifies for guardianship assistance or adoption
172.34 assistance, the financially responsible agency and the commissioner shall use the
172.35 eligibility requirements outlined in section 473 of the Social Security Act. In each case,

173.1 the agency paying the maintenance payments must be reimbursed for the costs from the
173.2 federal money available for this purpose.

173.3 Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance
173.4 payments as determined under subdivision 4, and an identical share of the pre-Northstar
173.5 Care foster care program under section 260C.4411, subdivision 1, the relative custody
173.6 assistance program under section 257.85, and the pre-Northstar Care for Children adoption
173.7 assistance program under chapter 259A. The commissioner may transfer funds into the
173.8 account if a deficit occurs.

173.9 Subd. 3. **Local share.** (a) The financially responsible agency at the time of
173.10 placement for foster care or finalization of the agreement for guardianship assistance or
173.11 adoption assistance shall pay the local share of the maintenance payments as determined
173.12 under subdivision 4, and an identical share of the pre-Northstar Care for Children foster
173.13 care program under section 260C.4411, subdivision 1, the relative custody assistance
173.14 program under section 257.85, and the pre-Northstar Care for Children adoption assistance
173.15 program under chapter 259A.

173.16 (b) The financially responsible agency shall pay the entire cost of any initial clothing
173.17 allowance, administrative payments to child caring agencies specified in section 317A.907,
173.18 or other support services it authorizes, except as provided under other provisions of law.

173.19 (c) In cases of federally required adoption assistance where there is no financially
173.20 responsible agency as provided in section 256N.24, subdivision 5, the commissioner
173.21 shall pay the local share.

173.22 (d) When an Indian child being placed in Minnesota meets title IV-E eligibility
173.23 defined in section 473(d) of the Social Security Act and is receiving guardianship
173.24 assistance or adoption assistance, the agency or entity assuming responsibility for the
173.25 child is responsible for the nonfederal share of the payment.

173.26 Subd. 4. **Nonfederal share.** (a) The commissioner shall establish a percentage share
173.27 of the maintenance payments, reduced by federal reimbursements under title IV-E of the
173.28 Social Security Act, to be paid by the state and to be paid by the financially responsible
173.29 agency.

173.30 (b) These state and local shares must initially be calculated based on the ratio of the
173.31 average appropriate expenditures made by the state and all financially responsible agencies
173.32 during calendar years 2011, 2012, 2013, and 2014. For purposes of this calculation,
173.33 appropriate expenditures for the financially responsible agencies must include basic and
173.34 difficulty of care payments for foster care reduced by federal reimbursements, but not
173.35 including any initial clothing allowance, administrative payments to child care agencies
173.36 specified in section 317A.907, child care, or other support or ancillary expenditures. For

174.1 purposes of this calculation, appropriate expenditures for the state shall include adoption
174.2 assistance and relative custody assistance, reduced by federal reimbursements.

174.3 (c) For each of the periods January 1, 2015, to June 30, 2016, fiscal years 2017, 2018,
174.4 and 2019, the commissioner shall adjust this initial percentage of state and local shares to
174.5 reflect the relative expenditure trends during calendar years 2011, 2012, 2013, and 2014,
174.6 taking into account appropriations for Northstar Care for Children and the turnover rates
174.7 of the components. In making these adjustments, the commissioner's goal shall be to make
174.8 these state and local expenditures other than the appropriations for Northstar Care to be
174.9 the same as they would have been had Northstar Care not been implemented, or if that
174.10 is not possible, proportionally higher or lower, as appropriate. The state and local share
174.11 percentages for fiscal year 2019 must be used for all subsequent years.

174.12 Subd. 5. **Adjustments for proportionate shares among financially responsible**
174.13 **agencies.** (a) The commissioner shall adjust the expenditures under subdivision 4 by each
174.14 financially responsible agency so that its relative share is proportional to its foster care
174.15 expenditures, with the goal of making the local share similar to what the county or tribe
174.16 would have spent had Northstar Care for Children not been enacted.

174.17 (b) For the period January 1, 2015, to June 30, 2016, the relative shares must be as
174.18 determined under subdivision 4 for calendar years 2011, 2012, 2013, and 2014 compared
174.19 with similar costs of all financially responsible agencies.

174.20 (c) For subsequent fiscal years, the commissioner shall update the relative shares
174.21 based on actual utilization of Northstar Care for Children by the financially responsible
174.22 agencies during the previous period, so that those using relatively more than they did
174.23 historically are adjusted upward and those using less are adjusted downward.

174.24 (d) The commissioner must ensure that the adjustments are not unduly influenced by
174.25 onetime events, anomalies, small changes that appear large compared to a narrow historic
174.26 base, or fluctuations that are the results of the transfer of responsibilities to tribal social
174.27 service agencies authorized in section 256.01, subdivision 14b, as part of the American
174.28 Indian Child Welfare Initiative.

174.29 Sec. 44. **[256N.28] ADMINISTRATION AND APPEALS.**

174.30 Subdivision 1. **Responsibilities.** (a) The financially responsible agency shall
174.31 determine the eligibility for Northstar Care for Children for children in foster care under
174.32 section 256N.21, and for those children determined eligible, shall further determine each
174.33 child's eligibility for title IV-E of the Social Security Act, provided the agency has such
174.34 authority under the state title IV-E plan.

175.1 (b) Subject to commissioner review and approval, the financially responsible agency
175.2 shall prepare the eligibility determination for Northstar Care for Children for children in
175.3 guardianship assistance under section 256N.22 and children in adoption assistance under
175.4 section 256N.23. The AFDC relatedness determination, when necessary to determine a
175.5 child's eligibility for title IV-E funding, shall be made only by an authorized agency
175.6 according to policies and procedures prescribed by the commissioner.

175.7 (c) The financially responsible agency is responsible for the administration of
175.8 Northstar Care for Children for children in foster care. The agency designated by the
175.9 commissioner is responsible for assisting the commissioner with the administration of
175.10 the Northstar Care for Children for children in guardianship assistance and adoption
175.11 assistance by conducting assessments, reassessments, negotiations, and other activities as
175.12 specified by the commissioner under subdivision 2.

175.13 Subd. 2. **Procedures, requirements, and deadlines.** The commissioner shall
175.14 specify procedures, requirements, and deadlines for the administration of Northstar Care
175.15 for Children in accordance with sections 256N.001 to 256N.28, including for children
175.16 transitioning into Northstar Care for Children under subdivision 7. The commissioner
175.17 shall periodically review all procedures, requirements, and deadlines, including the
175.18 assessment tool and process under section 256N.24, in consultation with counties, tribes,
175.19 and representatives of caregivers, and may alter them as needed.

175.20 Subd. 3. **Administration of title IV-E programs.** The title IV-E foster care,
175.21 guardianship assistance, and adoption assistance programs must operate within the
175.22 statutes, rules, and policies set forth by the federal government in the Social Security Act.

175.23 Subd. 4. **Reporting.** The commissioner shall specify required fiscal and statistical
175.24 reports under section 256.01, subdivision 2, paragraph (q), and other reports as necessary.

175.25 Subd. 5. **Promotion of programs.** Families who adopt a child under the
175.26 commissioner's guardianship must be informed as to the adoption tax credit. The
175.27 commissioner shall actively seek ways to promote the guardianship assistance and
175.28 adoption assistance programs, including informing prospective caregivers of eligible
175.29 children of the availability of guardianship assistance and adoption assistance.

175.30 Subd. 6. **Appeals and fair hearings.** (a) A caregiver has the right to appeal to the
175.31 commissioner under section 256.045 when eligibility for Northstar Care for Children is
175.32 denied, and when payment or the agreement for an eligible child is modified or terminated.

175.33 (b) A relative custodian or adoptive parent has additional rights to appeal to the
175.34 commissioner pursuant to section 256.045. These rights include when the commissioner
175.35 terminates or modifies the guardianship assistance or adoption assistance agreement or
175.36 when the commissioner denies an application for guardianship assistance or adoption

176.1 assistance. A prospective relative custodian or adoptive parent who disagrees with a
176.2 decision by the commissioner before transfer of permanent legal and physical custody or
176.3 finalization of the adoption may request review of the decision by the commissioner or
176.4 may appeal the decision under section 256.045. A guardianship assistance or adoption
176.5 assistance agreement must be signed and in effect before the court order that transfers
176.6 permanent legal and physical custody or the adoption finalization; however in some cases,
176.7 there may be extenuating circumstances as to why an agreement was not entered into
176.8 before finalization of permanency for the child. Caregivers who believe that extenuating
176.9 circumstances exist in the case of their child may request a fair hearing. Caregivers have the
176.10 responsibility of proving that extenuating circumstances exist. Caregivers must be required
176.11 to provide written documentation of each eligibility criterion at the fair hearing. Examples
176.12 of extenuating circumstances include: relevant facts regarding the child were known by
176.13 the placing agency and not presented to the caregivers before transfer of permanent legal
176.14 and physical custody or finalization of the adoption, or failure by the commissioner or a
176.15 designee to advise potential caregivers about the availability of guardianship assistance or
176.16 adoption assistance for children in the state foster care system. If an appeals judge finds
176.17 through the fair hearing process that extenuating circumstances existed and that the child
176.18 met all eligibility criteria at the time the transfer of permanent legal and physical custody
176.19 was ordered or the adoption was finalized, the effective date and any associated federal
176.20 financial participation shall be retroactive from the date of the request for a fair hearing.

176.21 Subd. 7. **Transitions from pre-Northstar Care for Children programs.** (a) A child
176.22 in foster care who remains with the same caregiver shall continue to receive benefits under
176.23 the pre-Northstar Care for Children foster care program under section 256.82. Transitions
176.24 to Northstar Care for Children must occur as provided in section 256N.21, subdivision 6.

176.25 (b) The commissioner may seek to transition into Northstar Care for Children a child
176.26 who is in pre-Northstar Care for Children relative custody assistance under section 257.85
176.27 or pre-Northstar Care for Children adoption assistance under chapter 259A, in accordance
176.28 with these priorities, in order of priority:

176.29 (1) improving permanency for a child or children;

176.30 (2) maintaining permanency for a child or children;

176.31 (3) administrative simplification;

176.32 (4) accessing additional federal funds;

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

176.35 (6) complying with federal regulations; and

176.36 (7) financial and budgetary constraints.

177.1 (c) Transitions shall be accomplished according to procedures, deadlines, and
177.2 requirements specified by the commissioner under subdivision 2.
177.3 (d) The commissioner may accomplish a transition of a child from pre-Northstar
177.4 Care for Children relative custody assistance under section 257.85 to the guardianship
177.5 assistance component of Northstar Care for Children by declaration and appropriate notice
177.6 to the caregiver, provided that the benefit for a child under this paragraph is not reduced.
177.7 (e) The commissioner may offer a transition of a child from pre-Northstar Care for
177.8 Children adoption assistance under chapter 259A to the adoption assistance component
177.9 of Northstar Care for Children by contacting the caregiver with an offer. The transition
177.10 must be accomplished only when the caregiver agrees to the offer. The caregiver shall
177.11 have a maximum of 90 days to review and accept the commissioner's offer. If the
177.12 commissioner's offer is not accepted within 90 days, the pre-Northstar Care for Children
177.13 adoption assistance agreement remains in effect until it terminates or a subsequent offer is
177.14 made by the commissioner.
177.15 (f) For a child transitioning into Northstar Care for Children, the commissioner shall
177.16 assign an equivalent assessment level based on the most recently completed supplemental
177.17 difficulty of care level assessment, unless the commissioner determines that arranging
177.18 for a new assessment under section 256N.24 would be more appropriate based on the
177.19 priorities specified in paragraph (b).
177.20 (g) For a child transitioning into Northstar Care for Children, regardless of the age
177.21 of the child, the commissioner shall use the rates under section 256N.26, subdivision 5,
177.22 unless the rates under section 256N.26, subdivisions 3 and 4, are more appropriate based
177.23 on the priorities specified in paragraph (b), as determined by the commissioner.
177.24 Subd. 8. **Purchase of child-specific adoption services.** The commissioner may
177.25 reimburse the placing agency for appropriate adoption services for children eligible
177.26 under section 259A.75.

177.27 Sec. 45. Minnesota Statutes 2012, section 257.85, subdivision 2, is amended to read:
177.28 Subd. 2. **Scope.** The provisions of this section apply to those situations in which
177.29 the legal and physical custody of a child is established with a relative or important friend
177.30 with whom the child has resided or had significant contact according to section 260C.515,
177.31 subdivision 4, by a district court order issued on or after July 1, 1997, but on or before
177.32 November 26, 2014, or a tribal court order issued on or after July 1, 2005, but on or
177.33 before November 26, 2014, when the child has been removed from the care of the parent
177.34 by previous district or tribal court order.

178.1 Sec. 46. Minnesota Statutes 2012, section 257.85, subdivision 5, is amended to read:

178.2 Subd. 5. **Relative custody assistance agreement.** (a) A relative custody assistance
178.3 agreement will not be effective, unless it is signed by the local agency and the relative
178.4 custodian no later than 30 days after the date of the order establishing permanent legal and
178.5 physical custody, and on or before November 26, 2014, except that a local agency may
178.6 enter into a relative custody assistance agreement with a relative custodian more than 30
178.7 days after the date of the order if it certifies that the delay in entering the agreement was
178.8 through no fault of the relative custodian and the agreement is signed and in effect on or
178.9 before November 26, 2014. There must be a separate agreement for each child for whom
178.10 the relative custodian is receiving relative custody assistance.

178.11 (b) Regardless of when the relative custody assistance agreement is signed by the
178.12 local agency and relative custodian, the effective date of the agreement shall be the date of
178.13 the order establishing permanent legal and physical custody.

178.14 (c) If MFIP is not the applicable program for a child at the time that a relative
178.15 custody assistance agreement is entered on behalf of the child, when MFIP becomes
178.16 the applicable program, if the relative custodian had been receiving custody assistance
178.17 payments calculated based upon a different program, the amount of relative custody
178.18 assistance payment under subdivision 7 shall be recalculated under the Minnesota family
178.19 investment program.

178.20 (d) The relative custody assistance agreement shall be in a form specified by the
178.21 commissioner and shall include provisions relating to the following:

178.22 (1) the responsibilities of all parties to the agreement;

178.23 (2) the payment terms, including the financial circumstances of the relative
178.24 custodian, the needs of the child, the amount and calculation of the relative custody
178.25 assistance payments, and that the amount of the payments shall be reevaluated annually;

178.26 (3) the effective date of the agreement, which shall also be the anniversary date for
178.27 the purpose of submitting the annual affidavit under subdivision 8;

178.28 (4) that failure to submit the affidavit as required by subdivision 8 will be grounds
178.29 for terminating the agreement;

178.30 (5) the agreement's expected duration, which shall not extend beyond the child's
178.31 eighteenth birthday;

178.32 (6) any specific known circumstances that could cause the agreement or payments
178.33 to be modified, reduced, or terminated and the relative custodian's appeal rights under
178.34 subdivision 9;

178.35 (7) that the relative custodian must notify the local agency within 30 days of any of
178.36 the following:

(i) a change in the child's status;

(ii) a change in the relationship between the relative custodian and the child;

(iii) a change in composition or level of income of the relative custodian's family;

(iv) a change in eligibility or receipt of benefits under MFIP, or other assistance program; and

(v) any other change that could affect eligibility for or amount of relative custody assistance;

(8) that failure to provide notice of a change as required by clause (7) will be grounds for terminating the agreement;

(9) that the amount of relative custody assistance is subject to the availability of state funds to reimburse the local agency making the payments;

(10) that the relative custodian may choose to temporarily stop receiving payments under the agreement at any time by providing 30 days' notice to the local agency and may choose to begin receiving payments again by providing the same notice but any payments the relative custodian chooses not to receive are forfeit; and

(11) that the local agency will continue to be responsible for making relative custody assistance payments under the agreement regardless of the relative custodian's place of residence.

Sec. 47. Minnesota Statutes 2012, section 257.85, subdivision 6, is amended to read:

Subd. 6. **Eligibility criteria.** <u>(a)</u> A local agency shall enter into a relative custody assistance agreement under subdivision 5 if it certifies that the following criteria are met:

(1) the juvenile court has determined or is expected to determine that the child, under the former or current custody of the local agency, cannot return to the home of the child's parents;

(2) the court, upon determining that it is in the child's best interests, has issued or is expected to issue an order transferring permanent legal and physical custody of the child; and

(3) the child either:

(i) is a member of a sibling group to be placed together; or

(ii) has a physical, mental, emotional, or behavioral disability that will require financial support.

When the local agency bases its certification that the criteria in clause (1) or (2) are met upon the expectation that the juvenile court will take a certain action, the relative custody assistance agreement does not become effective until and unless the court acts as expected.

180.1 (b) After November 26, 2014, new relative custody assistance agreements must not
180.2 be executed. Agreements that were signed by all parties on or before November 26, 2014,
180.3 and were not in effect because the proposed transfer of permanent legal and physical
180.4 custody of the child did not occur on or before November 26, 2014, must be renegotiated
180.5 under the terms of Northstar Care for Children in chapter 256N.

180.6 Sec. 48. **[259A.12] NO NEW EXECUTION OF ADOPTION ASSISTANCE**
180.7 **AGREEMENTS.**

180.8 After November 26, 2014, new adoption assistance agreements must not be executed
180.9 under this section. Agreements that were signed on or before November 26, 2014, and
180.10 were not in effect because the adoption finalization of the child did not occur on or before
180.11 November 26, 2014, must be renegotiated according to the terms of Northstar Care for
180.12 Children under chapter 256N. Agreements signed and in effect on or before November 26,
180.13 2014, must continue according to the terms of this section and applicable rules for the
180.14 duration of the agreement, unless the commissioner and the adoptive parents choose to
180.15 renegotiated the agreements under Northstar Care for Children consistent with section
180.16 256N.28, subdivision 7. After November 26, 2014, this section and associated rules must
180.17 be referred to as the pre-Northstar Care for Children adoption assistance program and
180.18 shall apply to children whose adoption assistance agreements were in effect on or before
180.19 November 26, 2014, and whose adoptive parents have not renegotiated their agreements
180.20 according to the terms of Northstar Care for Children.

180.21 Sec. 49. **[260C.4411] PRE-NORTHSTAR CARE FOR CHILDREN FOSTER**
180.22 **CARE PROGRAM.**

180.23 Subdivision 1. **Pre-Northstar Care for Children foster care program.** (a) For a
180.24 child placed in family foster care on or before December 31, 2014, the county of financial
180.25 responsibility under section 256G.02 or tribal agency authorized under section 256.01,
180.26 subdivision 14b, shall pay the local share under section 256N.27, subdivision 3, for foster
180.27 care maintenance including any difficulty of care as defined in Minnesota Rules, part
180.28 9560.0521, subparts 7 and 10. Family foster care includes:

180.29 (1) emergency relative placement under section 245A.035;

180.30 (2) licensed foster family settings, foster residence settings, or treatment foster care
180.31 settings, licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, served by a public
180.32 or private child care agency authorized by Minnesota Rules, parts 9545.0755 to 9545.0845;

180.33 (3) family foster care homes approved by a tribal agency; and

180.34 (4) unlicensed supervised settings for foster youth ages 18 to 21.

181.1 (b) The county of financial responsibility under section 256G.02 or tribal social
181.2 services agency authorized in section 256.01, subdivision 14b, shall pay the entire cost of
181.3 any initial clothing allowance, administrative payments to child care agencies specified
181.4 in section 317A.907, or any other support services it authorizes, except as otherwise
181.5 provided by law.

181.6 (c) The rates for the pre-Northstar Care for Children foster care program remain
181.7 those in effect on January 1, 2013, continuing the preexisting rate structure for foster
181.8 children who remain with the same caregivers and do not transition into Northstar Care for
181.9 Children under section 256N.21, subdivision 6.

181.10 (d) Difficulty of care payments must be maintained consistent with Minnesota Rules,
181.11 parts 9560.0652 and 9560.0653, using the established reassessment tool in part 9560.0654.
181.12 The preexisting rate structure for the pre-Northstar Care for Children foster care program
181.13 must be maintained, provided that when the number of foster children in the program is
181.14 less than ten percent of the population in 2012, the commissioner may apply the same
181.15 assessment tool to both the pre-Northstar Care for Children foster care program and
181.16 Northstar Care for Children under the authority granted in section 256N.24, subdivision 2.

181.17 (e) The county of financial responsibility under section 256G.02 or tribal agency
181.18 authorized under section 256.01, subdivision 14b, shall document the determined
181.19 pre-Northstar Care for Children foster care rate in the case record, including a description
181.20 of each condition on which the difficulty of care assessment is based. The difficulty
181.21 of care rate is reassessed:

181.22 (1) every 12 months;

181.23 (2) at the request of the foster parent; or

181.24 (3) if the child's level of need changes in the current foster home.

181.25 (f) The pre-Northstar Care for Children foster care program must maintain the
181.26 following existing program features:

181.27 (1) monthly payments must be made to the family foster home provider;

181.28 (2) notice and appeal procedures must be consistent with Minnesota Rules, part
181.29 9560.0665; and

181.30 (3) medical assistance eligibility for foster children must continue to be determined
181.31 according to section 256B.055.

181.32 (g) The county of financial responsibility under section 256G.02 or tribal agency
181.33 authorized under section 256.01, subdivision 14b, may continue existing program features,
181.34 including:

181.35 (1) establishing a local fund of county money through which the agency may
181.36 reimburse foster parents for the cost of repairing damage done to the home and contents by

182.1 the foster child and the additional care insurance premium cost of a child who possesses a
182.2 permit or license to drive a car; and
182.3 (2) paying a fee for specific services provided by the foster parent, based on the
182.4 parent's skills, experience, or training. This fee must not be considered foster care
182.5 maintenance.
182.6 (h) The following events end the child's enrollment in the pre-Northstar Care for
182.7 Children foster care program:
182.8 (1) reunification with parent or other relative;
182.9 (2) adoption or transfer of permanent legal and physical custody;
182.10 (3) removal from the current foster home to a different foster home;
182.11 (4) another event that ends the current placement episode; or
182.12 (5) attaining the age of 21.
182.13 Subd. 2. **Consideration of other programs.** (a) When a child in foster care
182.14 is eligible to receive a grant of Retirement Survivors Disability Insurance (RSDI)
182.15 or Supplemental Security Income for the aged, blind, and disabled, or a foster care
182.16 maintenance payment under title IV-E of the Social Security Act, United States Code, title
182.17 42, sections 670 to 676, the child's needs must be met through these programs. Every
182.18 effort must be made to establish a child's eligibility for a title IV-E grant to reimburse the
182.19 county or tribe from the federal funds available for this purpose.
182.20 (b) When a child in foster care qualifies for home and community-based waivered
182.21 services under section 256B.49 for community alternative care (CAC), community
182.22 alternatives for disabled individuals (CADI), or traumatic brain injury (TBI) waivers,
182.23 this service does not substitute for the child foster care program. When a foster child is
182.24 receiving waivered services benefits, the county of financial responsibility under section
182.25 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, assesses and
182.26 provides foster care maintenance including difficulty of care using the established tool in
182.27 Minnesota Rules, part 9560.0654. If it is determined that additional services are needed to
182.28 meet the child's needs in the home that are not or cannot be met by the foster care program,
182.29 the needs must be referred to the waivered service program.

182.30 Sec. 50. **[260C.4412] PAYMENT FOR RESIDENTIAL PLACEMENTS.**
182.31 When a child is placed in a foster care group residential setting under Minnesota
182.32 Rules, parts 2960.0020 to 2960.0710, foster care maintenance payments must be made on
182.33 behalf of the child to cover the cost of providing food, clothing, shelter, daily supervision,
182.34 school supplies, child's personal incidentals and supports, reasonable travel for visitation,
182.35 or other transportation needs associated with the items listed. Daily supervision in the

group residential setting includes routine day-to-day direction and arrangements to ensure the well-being and safety of the child. It may also include reasonable costs of administration and operation of the facility.

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

Sec. 51. **[260C.4413] INITIAL CLOTHING ALLOWANCE.**

(a) An initial clothing allowance must be available to a child eligible for:

(1) the pre-Northstar Care for Children foster care program under section 260C.4411, subdivision 1; and

(2) the Northstar Care for Children benefits under section 256N.21.

(b) An initial clothing allowance must also be available for a foster child in a group residential setting based on the child's individual needs during the first 60 days of the child's initial placement. The agency must consider the parent's ability to provide for a child's clothing needs and the residential facility contracts.

(c) The county of financial responsibility under section 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, shall approve an initial clothing allowance consistent with the child's needs. The amount of the initial clothing allowance must not exceed the monthly basic rate for the child's age group under section 256N.26, subdivision 3.

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

Sec. 52. Minnesota Statutes 2012, section 260C.446, is amended to read:

260C.446 DISTRIBUTION OF FUNDS RECOVERED FOR ASSISTANCE FURNISHED.

When any amount shall be recovered from any source for assistance furnished under the provisions of sections 260C.001 to 260C.421 ~~and 260C.441~~, there shall be paid into the treasury of the state or county in the proportion in which they have respectively contributed toward the total assistance paid.

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

Sec. 53. **REPEALER.**

(a) Minnesota Statutes 2012, sections 256.82, subdivision 4; and 260C.441, are repealed effective January 1, 2015.

184.1 (b) Minnesota Statutes 2012, section 256J.24, subdivision 10, is repealed effective
184.2 October 1, 2013, or upon approval from the United States Department of Agriculture,
184.3 whichever is later.

184.4 (c) Minnesota Rules, parts 9560.0650, subparts 1, 3, and 6; 9560.0651; and
184.5 9560.0655, are repealed effective January 1, 2015.

184.6 (d) Minnesota Rules, part 9502.0355, subpart 4, is repealed.

184.7 ARTICLE 4

184.8 STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES

184.9 Section 1. Minnesota Statutes 2012, section 245.4661, subdivision 5, is amended to read:

184.10 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with
184.11 the exception of the placement of a Minnesota specialty treatment facility as defined in
184.12 paragraph (c), must be developed under the direction of the county board, or multiple
184.13 county boards acting jointly, as the local mental health authority. The planning process
184.14 for each pilot shall include, but not be limited to, mental health consumers, families,
184.15 advocates, local mental health advisory councils, local and state providers, representatives
184.16 of state and local public employee bargaining units, and the department of human services.
184.17 As part of the planning process, the county board or boards shall designate a managing
184.18 entity responsible for receipt of funds and management of the pilot project.

184.19 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a
184.20 request for proposal for regions in which a need has been identified for services.

184.21 (c) For purposes of this section, Minnesota specialty treatment facility is defined as
184.22 an intensive rehabilitative mental health service under section 256B.0622, subdivision 2,
184.23 paragraph (b).

184.24 Sec. 2. Minnesota Statutes 2012, section 245.4661, subdivision 6, is amended to read:

184.25 Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the
184.26 commissioner shall facilitate integration of funds or other resources as needed and
184.27 requested by each project. These resources may include:

184.28 (1) residential services funds administered under Minnesota Rules, parts 9535.2000
184.29 to 9535.3000, in an amount to be determined by mutual agreement between the project's
184.30 managing entity and the commissioner of human services after an examination of the
184.31 county's historical utilization of facilities located both within and outside of the county
184.32 and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

184.33 (2) community support services funds administered under Minnesota Rules, parts
184.34 9535.1700 to 9535.1760;

185.1 (3) other mental health special project funds;

185.2 (4) medical assistance, general assistance medical care, MinnesotaCare and group
185.3 residential housing if requested by the project's managing entity, and if the commissioner
185.4 determines this would be consistent with the state's overall health care reform efforts; ~~and~~

185.5 (5) regional treatment center resources consistent with section 246.0136, subdivision
185.6 1~~.~~; and

185.7 (6) funds transferred from section 246.18, subdivision 8, for grants to providers to
185.8 participate in mental health specialty treatment services, awarded to providers through
185.9 a request for proposal process.

185.10 (b) The commissioner shall consider the following criteria in awarding start-up and
185.11 implementation grants for the pilot projects:

185.12 (1) the ability of the proposed projects to accomplish the objectives described in
185.13 subdivision 2;

185.14 (2) the size of the target population to be served; and

185.15 (3) geographical distribution.

185.16 (c) The commissioner shall review overall status of the projects initiatives at least
185.17 every two years and recommend any legislative changes needed by January 15 of each
185.18 odd-numbered year.

185.19 (d) The commissioner may waive administrative rule requirements which are
185.20 incompatible with the implementation of the pilot project.

185.21 (e) The commissioner may exempt the participating counties from fiscal sanctions
185.22 for noncompliance with requirements in laws and rules which are incompatible with the
185.23 implementation of the pilot project.

185.24 (f) The commissioner may award grants to an entity designated by a county board or
185.25 group of county boards to pay for start-up and implementation costs of the pilot project.

185.26 Sec. 3. Minnesota Statutes 2012, section 245.4682, subdivision 2, is amended to read:

185.27 Subd. 2. **General provisions.** (a) In the design and implementation of reforms to
185.28 the mental health system, the commissioner shall:

185.29 (1) consult with consumers, families, counties, tribes, advocates, providers, and
185.30 other stakeholders;

185.31 (2) bring to the legislature, and the State Advisory Council on Mental Health, by
185.32 January 15, 2008, recommendations for legislation to update the role of counties and to
185.33 clarify the case management roles, functions, and decision-making authority of health
185.34 plans and counties, and to clarify county retention of the responsibility for the delivery of
185.35 social services as required under subdivision 3, paragraph (a);

186.1 (3) withhold implementation of any recommended changes in case management
186.2 roles, functions, and decision-making authority until after the release of the report due
186.3 January 15, 2008;

186.4 (4) ensure continuity of care for persons affected by these reforms including
186.5 ensuring client choice of provider by requiring broad provider networks and developing
186.6 mechanisms to facilitate a smooth transition of service responsibilities;

186.7 (5) provide accountability for the efficient and effective use of public and private
186.8 resources in achieving positive outcomes for consumers;

186.9 (6) ensure client access to applicable protections and appeals; and

186.10 (7) make budget transfers necessary to implement the reallocation of services and
186.11 client responsibilities between counties and health care programs that do not increase the
186.12 state and county costs and efficiently allocate state funds.

186.13 (b) When making transfers under paragraph (a) necessary to implement movement
186.14 of responsibility for clients and services between counties and health care programs,
186.15 the commissioner, in consultation with counties, shall ensure that any transfer of state
186.16 grants to health care programs, including the value of case management transfer grants
186.17 under section 256B.0625, subdivision 20, does not exceed the value of the services being
186.18 transferred for the latest 12-month period for which data is available. The commissioner
186.19 may make quarterly adjustments based on the availability of additional data during the
186.20 first four quarters after the transfers first occur. If case management transfer grants under
186.21 section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior
186.22 to repeal, exceeds the value of the services being transferred, the difference becomes an
186.23 ongoing part of each county's adult ~~and children's~~ mental health grants under sections
186.24 245.4661~~, 245.4889,~~ and 256E.12.

186.25 (c) This appropriation is not authorized to be expended after December 31, 2010,
186.26 unless approved by the legislature.

186.27 Sec. 4. Minnesota Statutes 2012, section 246.18, subdivision 8, is amended to read:

186.28 Subd. 8. **State-operated services account.** (a) The state-operated services account is
186.29 established in the special revenue fund. Revenue generated by new state-operated services
186.30 listed under this section established after July 1, 2010, that are not enterprise activities must
186.31 be deposited into the state-operated services account, unless otherwise specified in law:

186.32 (1) intensive residential treatment services;

186.33 (2) foster care services; and

186.34 (3) psychiatric extensive recovery treatment services.

187.1 (b) Funds deposited in the state-operated services account are available to the
187.2 commissioner of human services for the purposes of:
187.3 (1) providing services needed to transition individuals from institutional settings
187.4 within state-operated services to the community when those services have no other
187.5 adequate funding source;
187.6 (2) grants to providers participating in mental health specialty treatment services
187.7 under section 245.4661; and
187.8 (3) to fund the operation of the Intensive Residential Treatment Service program in
187.9 Willmar.

187.10 Sec. 5. Minnesota Statutes 2012, section 246.18, is amended by adding a subdivision
187.11 to read:
187.12 Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds
187.13 to the account in subdivision 8 for noncovered allowable costs of a provider certified and
187.14 licensed under section 256B.0622, and operating under section 246.014.

187.15 Sec. 6. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
187.16 subdivision to read:
187.17 Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon
187.18 federal approval, whichever is later, medical assistance covers family psychoeducation
187.19 services provided to a child up to age 21 with a diagnosed mental health condition when
187.20 identified in the child's individual treatment plan and provided by a licensed mental health
187.21 professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a
187.22 clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who
187.23 has determined it medically necessary to involve family members in the child's care. For
187.24 the purposes of this subdivision, "family psychoeducation services" means information
187.25 or demonstration provided to an individual or family as part of an individual, family,
187.26 multifamily group, or peer group session to explain, educate, and support the child and
187.27 family in understanding a child's symptoms of mental illness, the impact on the child's
187.28 development, and needed components of treatment and skill development so that the
187.29 individual, family, or group can help the child to prevent relapse, prevent the acquisition
187.30 of comorbid disorders, and to achieve optimal mental health and long-term resilience.

187.31 Sec. 7. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
187.32 subdivision to read:

188.1 Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon
188.2 federal approval, whichever is later, medical assistance covers clinical care consultation
188.3 for a person up to age 21 who is diagnosed with a complex mental health condition or a
188.4 mental health condition that co-occurs with other complex and chronic conditions, when
188.5 described in the person's individual treatment plan and provided by a licensed mental
188.6 health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A. For
188.7 the purposes of this subdivision, "clinical care consultation" means communication from a
188.8 treating mental health professional to other providers not under the clinical supervision of
188.9 the treating mental health professional who are working with the same client to inform,
188.10 inquire, and instruct regarding the client's symptoms; strategies for effective engagement,
188.11 care, and intervention needs; and treatment expectations across service settings; and to
188.12 direct and coordinate clinical service components provided to the client and family.

188.13 Sec. 8. Minnesota Statutes 2012, section 256B.0946, is amended to read:

188.14 **256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.**

188.15 Subdivision 1. **Required covered service components.** (a) Effective ~~July 1, 2006,~~
188.16 upon enactment and subject to federal approval, medical assistance covers medically
188.17 necessary intensive treatment services described under paragraph (b) that are provided
188.18 by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2
188.19 who is placed in a ~~treatment~~ foster home licensed under Minnesota Rules, parts 2960.3000
188.20 to 2960.3340.

188.21 (b) Intensive treatment services to children with ~~severe emotional disturbance~~ mental
188.22 illness residing in ~~treatment~~ foster ~~care~~ family settings ~~must meet the relevant standards~~
188.23 ~~for mental health services under sections 245.487 to 245.4889. In addition,~~ that comprise
188.24 specific required service components provided in clauses (1) to (5), are reimbursed by
188.25 medical assistance ~~must~~ when they meet the following standards:

188.26 ~~(1) case management service component must meet the standards in Minnesota~~
188.27 ~~Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;~~

188.28 (1) psychotherapy provided by a mental health professional as defined in Minnesota
188.29 Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota
188.30 Rules, part 9505.0371, subpart 5, item C;

188.31 (2) ~~psychotherapy,~~ crisis assistance~~, and skills training components must meet the~~
188.32 provided according to standards for children's therapeutic services and supports in section
188.33 256B.0943; ~~and~~

189.1 (3) individual family, and group psychoeducation services under supervision of, 189.2 defined in subdivision 1a, paragraph (q), provided by a mental health professional. or a 189.3 clinical trainee;

189.4 (4) clinical care consultation, as defined in subdivision 1a, and provided by a mental 189.5 health professional or a clinical trainee; and

189.6 (5) service delivery payment requirements as provided under subdivision 4.

189.7 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have 189.8 the meanings given them.

189.9 (a) "Clinical care consultation" means communication from a treating clinician to 189.10 other providers working with the same client to inform, inquire, and instruct regarding 189.11 the client's symptoms, strategies for effective engagement, care and intervention needs, 189.12 and treatment expectations across service settings, including but not limited to the client's 189.13 school, social services, day care, probation, home, primary care, medication prescribers, 189.14 disabilities services, and other mental health providers and to direct and coordinate clinical 189.15 service components provided to the client and family.

189.16 (b) "Clinical supervision" means the documented time a clinical supervisor and 189.17 supervisee spend together to discuss the supervisee's work, to review individual client 189.18 cases, and for the supervisee's professional development. It includes the documented 189.19 oversight and supervision responsibility for planning, implementation, and evaluation of 189.20 services for a client's mental health treatment.

189.21 (c) "Clinical supervisor" means the mental health professional who is responsible 189.22 for clinical supervision.

189.23 (d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371, 189.24 subpart 5, item C;

189.25 (e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a, 189.26 including the development of a plan that addresses prevention and intervention strategies 189.27 to be used in a potential crisis, but does not include actual crisis intervention.

189.28 (f) "Culturally appropriate" means providing mental health services in a manner that 189.29 incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370, 189.30 subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural 189.31 strengths and resources to promote overall wellness.

189.32 (g) "Culture" means the distinct ways of living and understanding the world that 189.33 are used by a group of people and are transmitted from one generation to another or 189.34 adopted by an individual.

189.35 (h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 189.36 9505.0370, subpart 11.

190.1 (i) "Family" means a person who is identified by the client or the client's parent or
190.2 guardian as being important to the client's mental health treatment. Family may include,
190.3 but is not limited to, parents, foster parents, children, spouse, committed partners, former
190.4 spouses, persons related by blood or adoption, persons who are a part of the client's
190.5 permanency plan, or persons who are presently residing together as a family unit.
190.6 (j) "Foster care" has the meaning given in section 260C.007, subdivision 18.
190.7 (k) "Foster family setting" means the foster home in which the license holder resides.
190.8 (l) "Individual treatment plan" has the meaning given in Minnesota Rules, part
190.9 9505.0370, subpart 15.
190.10 (m) "Mental health practitioner" has the meaning given in Minnesota Rules, part
190.11 9505.0370, subpart 17.
190.12 (n) "Mental health professional" has the meaning given in Minnesota Rules, part
190.13 9505.0370, subpart 18.
190.14 (o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370,
190.15 subpart 20.
190.16 (p) "Parent" has the meaning given in section 260C.007, subdivision 25.
190.17 (q) "Psychoeducation services" means information or demonstration provided to
190.18 an individual, family, or group to explain, educate, and support the individual, family, or
190.19 group in understanding a child's symptoms of mental illness, the impact on the child's
190.20 development, and needed components of treatment and skill development so that the
190.21 individual, family, or group can help the child to prevent relapse, prevent the acquisition
190.22 of comorbid disorders, and to achieve optimal mental health and long-term resilience.
190.23 (r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370,
190.24 subpart 27.
190.25 (s) "Team consultation and treatment planning" means the coordination of treatment
190.26 plans and consultation among providers in a group concerning the treatment needs of the
190.27 child, including disseminating the child's treatment service schedule to all members of the
190.28 service team. Team members must include all mental health professionals working with
190.29 the child, a parent, the child unless the team lead or parent deem it clinically inappropriate,
190.30 and at least two of the following: an individualized education program case manager;
190.31 probation agent; children's mental health case manager; child welfare worker, including
190.32 adoption or guardianship worker; primary care provider; foster parent; and any other
190.33 member of the child's service team.
190.34 Subd. 2. **Determination of client eligibility.** ~~A client's eligibility to receive~~
190.35 ~~treatment foster care under this section shall be determined by~~ An eligible recipient is an
190.36 individual, from birth through age 20, who is currently placed in a foster home licensed

under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment~~,~~ and an evaluation of level of care needed, ~~and development of an individual treatment plan,~~ as defined in paragraphs (a) ~~to (c)~~ and (b).

(a) The diagnostic assessment must:

(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a ~~psychiatrist, licensed psychologist, or licensed independent clinical social worker that is~~ mental health professional or a clinical trainee;

(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;

(3) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments;

(4) be performed within 180 days ~~prior to~~ before the start of service; and

~~(2) include current diagnoses on all five axes of the client's current mental health status;~~

~~(3) determine whether or not a child meets the criteria for severe emotional disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness in section 245.462, subdivision 20; and~~

~~(4) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means a written summary, including current diagnoses on all five axes, by a mental health professional of the client's current mental status and service needs.~~

(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.

(b) The evaluation of level of care must be conducted by the placing county ~~with an instrument~~, tribe, or case manager in conjunction with the diagnostic assessment as described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care ~~instruments~~ tools annually and publish on the department's Web site.

~~(c) The individual treatment plan must be:~~

~~(1) based on the information in the client's diagnostic assessment;~~

~~(2) developed through a child-centered, family driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that~~

192.1 contain specific measurable treatment goals and objectives for the client and treatment
192.2 strategies for the client's family and foster family;
192.3 (3) reviewed at least once every 90 days and revised; and
192.4 (4) signed by the client or, if appropriate, by the client's parent or other person
192.5 authorized by statute to consent to mental health services for the client.
192.6 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for
192.7 intensive children's mental health services in a foster family setting must be certified
192.8 by the state and have a service provision contract with a county board or a reservation
192.9 tribal council and must be able to demonstrate the ability to provide all of the services
192.10 required in this section.
192.11 (b) For purposes of this section, a provider agency must have an individual
192.12 placement agreement for each recipient and must be a licensed child placing agency, under
192.13 Minnesota Rules, parts 9543.0010 to 9543.0150, and either be:
192.14 (1) a county county-operated entity certified by the state;
192.15 (2) an Indian Health Services facility operated by a tribe or tribal organization under
192.16 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
192.17 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or
192.18 (3) a noncounty entity under contract with a county board.
192.19 (c) Certified providers that do not meet the service delivery standards required in
192.20 this section shall be subject to a decertification process.
192.21 (d) For the purposes of this section, all services delivered to a client must be
192.22 provided by a mental health professional or a clinical trainee.
192.23 Subd. 4. **Eligible provider responsibilities Service delivery payment**
192.24 **requirements.** (a) To be an eligible provider for payment under this section, a provider
192.25 must develop and practice written policies and procedures for treatment foster care services
192.26 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), clauses (1),
192.27 (2), and (3) and comply with the following requirements in paragraphs (b) to (n).
192.28 (b) In delivering services under this section, a treatment foster care provider must
192.29 ensure that staff caseload size reasonably enables the provider to play an active role in
192.30 service planning, monitoring, delivering, and reviewing for discharge planning to meet
192.31 the needs of the client, the client's foster family, and the birth family, as specified in each
192.32 client's individual treatment plan.
192.33 (b) A qualified clinical supervisor, as defined in and performing in compliance with
192.34 Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and
192.35 provision of services described in this section.

193.1 (c) Each client receiving treatment services must receive an extended diagnostic
193.2 assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within
193.3 30 days of enrollment in this service unless the client has a previous extended diagnostic
193.4 assessment that the client, parent, and mental health professional agree still accurately
193.5 describes the client's current mental health functioning.

193.6 (d) Each previous and current mental health, school, and physical health treatment
193.7 provider must be contacted to request documentation of treatment and assessments that the
193.8 eligible client has received and this information must be reviewed and incorporated into
193.9 the diagnostic assessment and team consultation and treatment planning review process.

193.10 (e) Each client receiving treatment must be assessed for a trauma history and
193.11 the client's treatment plan must document how the results of the assessment will be
193.12 incorporated into treatment.

193.13 (f) Each client receiving treatment services must have an individual treatment plan
193.14 that is reviewed, evaluated, and signed every 90 days using the team consultation and
193.15 treatment planning process, as defined in subdivision 1a, paragraph (s).

193.16 (g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided
193.17 in accordance with the client's individual treatment plan.

193.18 (h) Each client must have a crisis assistance plan within ten days of initiating
193.19 services and must have access to clinical phone support 24 hours per day, seven days per
193.20 week, during the course of treatment, and the crisis plan must demonstrate coordination
193.21 with the local or regional mobile crisis intervention team.

193.22 (i) Services must be delivered and documented at least three days per week, equaling
193.23 at least six hours of treatment per week, unless reduced units of service are specified on
193.24 the treatment plan as part of transition or on a discharge plan to another service or level of
193.25 care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

193.26 (j) Location of service delivery must be in the client's home, day care setting,
193.27 school, or other community-based setting that is specified on the client's individualized
193.28 treatment plan.

193.29 (k) Treatment must be developmentally and culturally appropriate for the client.

193.30 (l) Services must be delivered in continual collaboration and consultation with the
193.31 client's medical providers and, in particular, with prescribers of psychotropic medications,
193.32 including those prescribed on an off-label basis, and members of the service team must be
193.33 aware of the medication regimen and potential side effects.

193.34 (m) Parents, siblings, foster parents, and members of the child's permanency plan
193.35 must be involved in treatment and service delivery unless otherwise noted in the treatment
193.36 plan.

194.1 (n) Transition planning for the child must be conducted starting with the first
194.2 treatment plan and must be addressed throughout treatment to support the child's
194.3 permanency plan and postdischarge mental health service needs.
194.4 Subd. 5. **Service authorization.** The commissioner will administer authorizations
194.5 for services under this section in compliance with section 256B.0625, subdivision 25.
194.6 Subd. 6. **Excluded services.** (a) Services in clauses (1) to (4) (7) are not covered
194.7 under this section and are not eligible for medical assistance payment as components of
194.8 intensive treatment in foster care services, but may be billed separately:
194.9 (1) treatment foster care services provided in violation of medical assistance policy
194.10 in Minnesota Rules, part 9505.0220;
194.11 (2) service components of children's therapeutic services and supports
194.12 simultaneously provided by more than one treatment foster care provider;
194.13 (3) home and community-based waiver services; and
194.14 (4) treatment foster care services provided to a child without a level of care
194.15 determination according to section 245.4885, subdivision 1.
194.16 (1) inpatient psychiatric hospital treatment;
194.17 (2) mental health targeted case management;
194.18 (3) partial hospitalization;
194.19 (4) medication management;
194.20 (5) children's mental health day treatment services;
194.21 (6) crisis response services under section 256B.0944; and
194.22 (7) transportation.
194.23 (b) Children receiving intensive treatment in foster care services are not eligible for
194.24 medical assistance reimbursement for the following services while receiving intensive
194.25 treatment in foster care:
194.26 (1) mental health case management services under section 256B.0625, subdivision
194.27 20; and
194.28 (2) (1) psychotherapy and skill skills training components of children's therapeutic
194.29 services and supports under section 256B.0625, subdivision 35b.;
194.30 (2) mental health behavioral aide services as defined in section 256B.0943,
194.31 subdivision 1, paragraph (m);
194.32 (3) home and community-based waiver services;
194.33 (4) mental health residential treatment; and
194.34 (5) room and board costs as defined in section 256I.03, subdivision 6.
194.35 Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall
194.36 establish a single daily per-client encounter rate for intensive treatment in foster care

195.1 services. The rate must be constructed to cover only eligible services delivered to an
195.2 eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

195.3 Sec. 9. Minnesota Statutes 2012, section 256B.761, is amended to read:

195.4 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

195.5 (a) Effective for services rendered on or after July 1, 2001, payment for medication
195.6 management provided to psychiatric patients, outpatient mental health services, day
195.7 treatment services, home-based mental health services, and family community support
195.8 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
195.9 50th percentile of 1999 charges.

195.10 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
195.11 services provided by an entity that operates: (1) a Medicare-certified comprehensive
195.12 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
195.13 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
195.14 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
195.15 when those services are provided within the comprehensive outpatient rehabilitation
195.16 facility and provided to residents of nursing facilities owned by the entity.

195.17 (c) The commissioner shall establish three levels of payment for mental health
195.18 diagnostic assessment, based on three levels of complexity. The aggregate payment under
195.19 the tiered rates must not exceed the projected aggregate payments for mental health
195.20 diagnostic assessment under the previous single rate. The new rate structure is effective
195.21 January 1, 2011, or upon federal approval, whichever is later.

195.22 (d) In addition to rate increases otherwise provided, the commissioner may
195.23 restructure coverage policy and rates to improve access to adult rehabilitative mental
195.24 health services under section 256B.0623 and related mental health support services under
195.25 section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and
195.26 2016, the projected state share of increased costs due to this paragraph is transferred
195.27 from adult mental health grants under sections 245.4661 and 256E.12. The transfer for
195.28 fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments
195.29 made to managed care plans and county-based purchasing plans under sections 256B.69,
195.30 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

195.31 **ARTICLE 5**

195.32 **DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY**

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

196.1 Subd. 7. **Use of data.** (a) Except as otherwise provided in subdivision 7a or sections
196.2 244.052 and 299C.093, the data provided under this section is private data on individuals
196.3 under section 13.02, subdivision 12.
196.4 (b) The data may be used only ~~for~~ by law enforcement and corrections agencies for
196.5 law enforcement and corrections purposes.
196.6 (c) The commissioner of human services is authorized to have access to the data for:
196.7 (1) state-operated services, as defined in section 246.014, ~~are also authorized to~~
196.8 ~~have access to the data~~ for the purposes described in section 246.13, subdivision 2,
196.9 paragraph (b); and
196.10 (2) purposes of completing background studies under chapter 245C.

196.11 Sec. 2. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision
196.12 to read:
196.13 Subd. 4a. **Agency background studies.** (a) The commissioner shall develop
196.14 and implement an electronic process for the regular transfer of new criminal history
196.15 information that is added to the Minnesota court information system. The commissioner's
196.16 system must include for review only information that relates to individuals who have been
196.17 the subject of a background study under this chapter that remain affiliated with the agency
196.18 that initiated the background study. For purposes of this paragraph, an individual remains
196.19 affiliated with an agency that initiated the background study until the agency informs the
196.20 commissioner that the individual is no longer affiliated. When any individual no longer
196.21 affiliated according to this paragraph returns to a position requiring a background study
196.22 under this chapter, the agency with whom the individual is again affiliated shall initiate
196.23 a new background study regardless of the length of time the individual was no longer
196.24 affiliated with the agency.
196.25 (b) The commissioner shall develop and implement an online system for agencies that
196.26 initiate background studies under this chapter to access and maintain records of background
196.27 studies initiated by that agency. The system must show all active background study subjects
196.28 affiliated with that agency and the status of each individual's background study. Each
196.29 agency that initiates background studies must use this system to notify the commissioner
196.30 of discontinued affiliation for purposes of the processes required under paragraph (a).

196.31 Sec. 3. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:
196.32 Subdivision 1. **Background studies conducted by Department of Human**
196.33 **Services.** (a) For a background study conducted by the Department of Human Services,
196.34 the commissioner shall review:

197.1 (1) information related to names of substantiated perpetrators of maltreatment of
197.2 vulnerable adults that has been received by the commissioner as required under section
197.3 626.557, subdivision 9c, paragraph (j);
197.4 (2) the commissioner's records relating to the maltreatment of minors in licensed
197.5 programs, and from findings of maltreatment of minors as indicated through the social
197.6 service information system;
197.7 (3) information from juvenile courts as required in subdivision 4 for individuals
197.8 listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;
197.9 (4) information from the Bureau of Criminal Apprehension, including information
197.10 regarding a background study subject's registration in Minnesota as a predatory offender
197.11 under section 243.166;
197.12 (5) except as provided in clause (6), information from the national crime information
197.13 system when the commissioner has reasonable cause as defined under section 245C.05,
197.14 subdivision 5; and
197.15 (6) for a background study related to a child foster care application for licensure or
197.16 adoptions, the commissioner shall also review:
197.17 (i) information from the child abuse and neglect registry for any state in which the
197.18 background study subject has resided for the past five years; and
197.19 (ii) information from national crime information databases, when the background
197.20 study subject is 18 years of age or older.
197.21 (b) Notwithstanding expungement by a court, the commissioner may consider
197.22 information obtained under paragraph (a), clauses (3) and (4), unless the commissioner
197.23 received notice of the petition for expungement and the court order for expungement is
197.24 directed specifically to the commissioner.
197.25 (c) The commissioner shall also review criminal history information received
197.26 according to section 245C.04, subdivision 4a, from the Minnesota court information
197.27 system that relates to individuals who have already been studied under this chapter and
197.28 who remain affiliated with the agency that initiated the background study.

197.29 Sec. 4. **[245E.01] CHILD CARE PROVIDER AND RECIPIENT FRAUD**
197.30 **INVESTIGATIONS WITHIN THE CHILD CARE ASSISTANCE PROGRAM.**
197.31 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this
197.32 subdivision have the meanings given them.
197.33 (b) "Applicant" has the meaning given in section 119B.011, subdivision 2.
197.34 (c) "Child care assistance program" means any of the assistance programs under
197.35 chapter 119B.

198.1 (d) "Commissioner" means the commissioner of human services.
198.2 (e) "Controlling individual" has the meaning given in section 245A.02, subdivision
198.3 5a.
198.4 (f) "County" means a local county child care assistance program staff or
198.5 subcontracted staff, or a county investigator acting on behalf of the commissioner.
198.6 (g) "Department" means the Department of Human Services.
198.7 (h) "Financial misconduct" or "misconduct" means an entity's or individual's acts or
198.8 omissions that result in fraud and abuse or error against the Department of Human Services.
198.9 (i) "Identify" means to furnish the full name, current or last known address, phone
198.10 number, and e-mail address of the individual or business entity.
198.11 (j) "License holder" has the meaning given in section 245A.02, subdivision 9.
198.12 (k) "Mail" means the use of any mail service with proof of delivery and receipt.
198.13 (l) "Provider" means either a provider as defined in section 119B.011, subdivision
198.14 19, or a legal unlicensed provider as defined in section 119B.011, subdivision 16.
198.15 (m) "Recipient" means a family receiving assistance as defined under section
198.16 119B.011, subdivision 13.
198.17 (n) "Terminate" means revocation of participation in the child care assistance
198.18 program.
198.19 Subd. 2. **Investigating provider or recipient financial misconduct.** The
198.20 department shall investigate alleged or suspected financial misconduct by providers and
198.21 errors related to payments issued by the child care assistance program under this chapter.
198.22 Recipients, employees, and staff persons may be investigated when the evidence shows
198.23 that their conduct is related to the financial misconduct of a provider, license holder,
198.24 or controlling individual.
198.25 Subd. 3. **Scope of investigations.** (a) The department may contact any person,
198.26 agency, organization, or other entity that is necessary to an investigation.
198.27 (b) The department may examine or interview any individual, document, or piece of
198.28 evidence that may lead to information that is relevant to child care assistance program
198.29 benefits, payments, and child care provider authorizations. This includes, but is not
198.30 limited to:
198.31 (1) child care assistance program payments;
198.32 (2) services provided by the program or related to child care assistance program
198.33 recipients;
198.34 (3) services provided to a provider;
198.35 (4) provider financial records of any type;
198.36 (5) daily attendance records of the children receiving services from the provider;

199.1 (6) billings; and

199.2 (7) verification of the credentials of a license holder, controlling individual,
199.3 employee, staff person, contractor, subcontractor, and entities under contract with the
199.4 provider to provide services or maintain service and the provider's financial records
199.5 related to those services.

199.6 Subd. 4. **Determination of investigation.** After completing its investigation, the
199.7 department shall issue one of the following determinations:

199.8 (1) no violation of child care assistance requirements occurred;

199.9 (2) there is insufficient evidence to show that a violation of child care assistance
199.10 requirements occurred;

199.11 (3) a preponderance of evidence shows a violation of child care assistance program
199.12 law, rule, or policy; or

199.13 (4) there exists a credible allegation of fraud.

199.14 Subd. 5. **Actions or administrative sanctions.** (a) In addition to section 256.98,
199.15 after completing the determination under subdivision 4, the department may take one or
199.16 more of the actions or sanctions specified in this subdivision.

199.17 (b) The department may take the following actions:

199.18 (1) refer the investigation to law enforcement or a county attorney for possible
199.19 criminal prosecution;

199.20 (2) refer relevant information to the department's licensing division, the child care
199.21 assistance program, the Department of Education, the federal child and adult care food
199.22 program, or appropriate child or adult protection agency;

199.23 (3) enter into a settlement agreement with a provider, license holder, controlling
199.24 individual, or recipient; or

199.25 (4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction
199.26 for possible civil action under the Minnesota False Claims Act, chapter 15C.

199.27 (c) The department may impose sanctions by:

199.28 (1) pursuing administrative disqualification through hearings or waivers;

199.29 (2) establishing and seeking monetary recovery or recoupment; or

199.30 (3) issuing an order of corrective action that states the practices that are violations of
199.31 child care assistance program policies, laws, or regulations, and that they must be corrected.

199.32 Subd. 6. **Duty to provide access.** (a) A provider, license holder, controlling
199.33 individual, employee, staff person, or recipient has an affirmative duty to provide access
199.34 upon request to information specified under subdivision 8 or the program facility.

200.1 (b) Failure to provide access may result in denial or termination of authorizations for
200.2 or payments to a recipient, provider, license holder, or controlling individual in the child
200.3 care assistance program.

200.4 (c) When a provider fails to provide access, a 15-day notice of denial or termination
200.5 must be issued to the provider, which prohibits the provider from participating in the child
200.6 care assistance program. Notice must be sent to recipients whose children are under the
200.7 provider's care pursuant to Minnesota Rules, part 3400.0185.

200.8 (d) If the provider continues to fail to provide access at the expiration of the 15-day
200.9 notice period, child care assistance program payments to the provider must be denied
200.10 beginning the 16th day following notice of the initial failure or refusal to provide access.
200.11 The department may rescind the denial based upon good cause if the provider submits in
200.12 writing a good cause basis for having failed or refused to provide access. The writing must
200.13 be postmarked no later than the 15th day following the provider's notice of initial failure
200.14 to provide access. Additionally, the provider, license holder, or controlling individual
200.15 must immediately provide complete, ongoing access to the department. Repeated failures
200.16 to provide access must, after the initial failure or for any subsequent failure, result in
200.17 termination from participation in the child care assistance program.

200.18 (e) The department, at its own expense, may photocopy or otherwise duplicate
200.19 records referenced in subdivision 8. Photocopying must be done on the provider's
200.20 premises on the day of the request or other mutually agreeable time, unless removal of
200.21 records is specifically permitted by the provider. If requested, a provider, license holder,
200.22 or controlling individual, or a designee, must assist the investigator in duplicating any
200.23 record, including a hard copy or electronically stored data, on the day of the request.

200.24 (f) A provider, license holder, controlling individual, employee, or staff person must
200.25 grant the department access during the department's normal business hours, and any hours
200.26 that the program is operated, to examine the provider's program or the records listed in
200.27 subdivision 8. A provider shall make records available at the provider's place of business
200.28 on the day for which access is requested, unless the provider and the department both agree
200.29 otherwise. The department's normal business hours are 8:00 a.m. to 5:00 p.m., Monday
200.30 through Friday, excluding state holidays as defined in section 645.44, subdivision 5.

200.31 Subd. 7. **Honest and truthful statements.** It shall be unlawful for a provider,
200.32 license holder, controlling individual, or recipient to:

200.33 (1) falsify, conceal, or cover up by any trick, scheme, or device a material fact;

200.34 (2) make any materially false, fictitious, or fraudulent statement or representation; or

200.35 (3) make or use any false writing or document knowing the same to contain any
200.36 materially false, fictitious, or fraudulent statement or entry related to any child care

201.1 assistance program services that the provider, license holder, or controlling individual
201.2 supplies or in relation to any child care assistance payments received by a provider, license
201.3 holder, or controlling individual or to any fraud investigator or law enforcement officer
201.4 conducting a financial misconduct investigation.

201.5 Subd. 8. **Record retention.** (a) The following records must be maintained,
201.6 controlled, and made immediately accessible to license holders, providers, and controlling
201.7 individuals. The records must be organized and labeled to correspond to categories that
201.8 make them easy to identify so that they can be made available immediately upon request
201.9 to an investigator acting on behalf of the commissioner at the provider's place of business:

201.10 (1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting
201.11 records;

201.12 (2) daily attendance records required by and that comply with section 119B.125,
201.13 subdivision 6;

201.14 (3) billing transmittal forms requesting payments from the child care assistance
201.15 program and billing adjustments related to child care assistance program payments;

201.16 (4) records identifying all persons, corporations, partnerships, and entities with an
201.17 ownership or controlling interest in the provider's child care business;

201.18 (5) employee records identifying those persons currently employed by the provider's
201.19 child care business or who have been employed by the business at any time within the
201.20 previous five years. The records must include each employee's name, hourly and annual
201.21 salary, qualifications, position description, job title, and dates of employment. In addition,
201.22 employee records that must be made available include the employee's time sheets, current
201.23 home address of the employee or last known address of any former employee, and
201.24 documentation of background studies required under chapter 119B or 245C;

201.25 (6) records related to transportation of children in care, including but not limited to:

201.26 (i) the dates and times that transportation is provided to children for transportation to
201.27 and from the provider's business location for any purpose. For transportation related to
201.28 field trips or locations away from the provider's business location, the names and addresses
201.29 of those field trips and locations must also be provided;

201.30 (ii) the name, business address, phone number, and Web site address, if any, of the
201.31 transportation service utilized; and

201.32 (iii) all billing or transportation records related to the transportation.

201.33 (b) A provider, license holder, or controlling individual must retain all records
201.34 in paragraph (a) for at least six years after the date the record is created. Microfilm or
201.35 electronically stored records satisfy the record keeping requirements of this subdivision.

202.1 (c) A provider, license holder, or controlling individual who withdraws or is
202.2 terminated from the child care assistance program must retain the records required under
202.3 this subdivision and make them available to the department on demand.

202.4 (d) If the ownership of a provider changes, the transferor, unless otherwise provided
202.5 by law or by written agreement with the transferee, is responsible for maintaining,
202.6 preserving, and upon request from the department, making available the records related to
202.7 the provider that were generated before the date of the transfer. Any written agreement
202.8 affecting this provision must be held in the possession of the transferor and transferee.
202.9 The written agreement must be provided to the department or county immediately upon
202.10 request, and the written agreement must be retained by the transferor and transferee for six
202.11 years after the agreement is fully executed.

202.12 (e) In the event of an appealed case, the provider must retain all records required in
202.13 this subdivision for the duration of the appeal or six years, whichever is longer.

202.14 (f) A provider's use of electronic record keeping or electronic signatures is governed
202.15 by chapter 325L.

202.16 Subd. 9. **Factors regarding imposition of administrative sanctions.** (a) The
202.17 department shall consider the following factors in determining the administrative sanctions
202.18 to be imposed:

202.19 (1) nature and extent of financial misconduct;

202.20 (2) history of financial misconduct;

202.21 (3) actions taken or recommended by other state agencies, other divisions of the
202.22 department, and court and administrative decisions;

202.23 (4) prior imposition of sanctions;

202.24 (5) size and type of provider;

202.25 (6) information obtained through an investigation from any source;

202.26 (7) convictions or pending criminal charges; and

202.27 (8) any other information relevant to the acts or omissions related to the financial
202.28 misconduct.

202.29 (b) Any single factor under paragraph (a) may be determinative of the department's
202.30 decision of whether and what sanctions are imposed.

202.31 Subd. 10. **Written notice of department sanction.** (a) The department shall give
202.32 notice in writing to a person of an administrative sanction that is to be imposed. The notice
202.33 shall be sent by mail as defined in subdivision 1, paragraph (k).

202.34 (b) The notice shall state:

202.35 (1) the factual basis for the department's determination;

202.36 (2) the sanction the department intends to take;

203.1 (3) the dollar amount of the monetary recovery or recoupment, if any;
203.2 (4) how the dollar amount was computed;
203.3 (5) the right to dispute the department's determination and to provide evidence;
203.4 (6) the right to appeal the department's proposed sanction; and
203.5 (7) the option to meet informally with department staff, and to bring additional
203.6 documentation or information, to resolve the issues.
203.7 (c) In cases of determinations resulting in denial or termination of payments, in
203.8 addition to the requirements of paragraph (b), the notice must state:
203.9 (1) the length of the denial or termination;
203.10 (2) the requirements and procedures for reinstatement; and
203.11 (3) the provider's right to submit documents and written arguments against the
203.12 denial or termination of payments for review by the department before the effective date
203.13 of denial or termination.
203.14 (d) The submission of documents and written argument for review by the department
203.15 under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the
203.16 deadline for filing an appeal.
203.17 (e) Unless timely appealed, the effective date of the proposed sanction shall be 30
203.18 days after the license holder's, provider's, controlling individual's, or recipient's receipt of
203.19 the notice. If a timely appeal is made, the proposed sanction shall be delayed pending
203.20 the final outcome of the appeal. Implementation of a proposed sanction following the
203.21 resolution of a timely appeal may be postponed if, in the opinion of the department, the
203.22 delay of sanction is necessary to protect the health or safety of children in care. The
203.23 department may consider the economic hardship of a person in implementing the proposed
203.24 sanction, but economic hardship shall not be a determinative factor in implementing the
203.25 proposed sanction.
203.26 (f) Requests for an informal meeting to attempt to resolve issues and requests
203.27 for appeals must be sent or delivered to the department's Office of Inspector General,
203.28 Financial Fraud and Abuse Division.
203.29 Subd. 11. **Appeal of department sanction under this section.** (a) If the department
203.30 does not pursue a criminal action against a provider, license holder, controlling individual,
203.31 or recipient for financial misconduct, but the department imposes an administrative
203.32 sanction, any individual or entity against whom the sanction was imposed may appeal the
203.33 department's administrative sanction under this section pursuant to section 119B.16 or
203.34 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:
203.35 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
203.36 amount involved for each disputed item, if appropriate;

204.1 (2) the computation that is believed to be correct, if appropriate;

204.2 (3) the authority in the statute or rule relied upon for each disputed item; and

204.3 (4) the name, address, and phone number of the person at the provider's place of
204.4 business with whom contact may be made regarding the appeal.

204.5 (b) An appeal is considered timely only if postmarked or received by the
204.6 department's Office of Inspector General, Financial Fraud and Abuse Division within 30
204.7 days after receiving a notice of department sanction.

204.8 (c) Before the appeal hearing, the department may deny or terminate authorizations
204.9 or payment to the entity or individual if the department determines that the action is
204.10 necessary to protect the public welfare or the interests of the child care assistance program.

204.11 Subd. 12. **Consolidated hearings with licensing sanction.** If a financial
204.12 misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing
204.13 sanction exists for which there is an appeal hearing right and the sanction is timely
204.14 appealed, and the overpayment recovery action and licensing sanction involve the same
204.15 set of facts, the overpayment recovery action and licensing sanction must be consolidated
204.16 in the contested case hearing related to the licensing sanction.

204.17 Subd. 13. **Grounds for and methods of monetary recovery.** (a) The department
204.18 may obtain monetary recovery from a provider who has been improperly paid by the
204.19 child care assistance program, regardless of whether the error was intentional or county
204.20 error. The department does not need to establish a pattern as a precondition of monetary
204.21 recovery of erroneous or false billing claims, duplicate billing claims, or billing claims
204.22 based on false statements or financial misconduct.

204.23 (b) The department shall obtain monetary recovery from providers by the following
204.24 means:

204.25 (1) permitting voluntary repayment of money, either in lump-sum payment or
204.26 installment payments;

204.27 (2) using any legal collection process;

204.28 (3) deducting or withholding program payments; or

204.29 (4) utilizing the means set forth in chapter 16D.

204.30 Subd. 14. **Reporting of suspected fraudulent activity.** (a) A person who, in
204.31 good faith, makes a report of or testifies in any action or proceeding in which financial
204.32 misconduct is alleged, and who is not involved in, has not participated in, or has not aided
204.33 and abetted, conspired, or colluded in the financial misconduct, shall have immunity from
204.34 any liability, civil or criminal, that results by reason of the person's report or testimony.
204.35 For the purpose of any proceeding, the good faith of any person reporting or testifying
204.36 under this provision shall be presumed.

205.1 (b) If a person that is or has been involved in, participated in, aided and abetted,
205.2 conspired, or colluded in the financial misconduct reports the financial misconduct,
205.3 the department may consider that person's report and assistance in investigating the
205.4 misconduct as a mitigating factor in the department's pursuit of civil, criminal, or
205.5 administrative remedies.

205.6 Subd. 15. **Data privacy.** Data of any kind obtained or created in relation to a provider
205.7 or recipient investigation under this section is defined, classified, and protected the same as
205.8 all other data under section 13.46, and this data has the same classification as licensing data.

205.9 Subd. 16. **Monetary recovery; random sample extrapolation.** The department is
205.10 authorized to calculate the amount of monetary recovery from a provider, license holder, or
205.11 controlling individual based upon extrapolation from a statistical random sample of claims
205.12 submitted by the provider, license holder, or controlling individual and paid by the child
205.13 care assistance program. The department's random sample extrapolation shall constitute a
205.14 rebuttable presumption of the accuracy of the calculation of monetary recovery. If the
205.15 presumption is not rebutted by the provider, license holder, or controlling individual in the
205.16 appeal process, the department shall use the extrapolation as the monetary recovery figure.
205.17 The department may use sampling and extrapolation to calculate the amount of monetary
205.18 recovery if the claims to be reviewed represent services to 50 or more children in care.

205.19 Subd. 17. **Effect of department's monetary penalty determination.** Unless
205.20 a timely and proper appeal is received by the department's Office of Inspector General,
205.21 Financial Fraud and Abuse Division, the department's administrative determination or
205.22 sanction shall be considered a final department determination.

205.23 Subd. 18. **Office of Inspector General recoveries.** Overpayment recoveries
205.24 resulting from child care provider fraud investigations initiated by the department's Office
205.25 of Inspector General's fraud investigations staff are excluded from the county recovery
205.26 provision in section 119B.11, subdivision 3.

205.27 Sec. 5. Minnesota Statutes 2012, section 256B.04, subdivision 21, is amended to read:

205.28 Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for
205.29 Medicare and Medicaid Services determines that a provider is designated "high-risk," the
205.30 commissioner may withhold payment from providers within that category upon initial
205.31 enrollment for a 90-day period. The withholding for each provider must begin on the date
205.32 of the first submission of a claim.

205.33 (b) An enrolled provider that is also licensed by the commissioner under chapter
205.34 245A must designate an individual as the entity's compliance officer. The compliance
205.35 officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the ~~Minnesota Department of Human Services~~ commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate

207.1 Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and
207.2 criteria are not subject to the requirements of chapter 14. The commissioner's designations
207.3 are not subject to administrative appeal.

207.4 (f) As a condition of enrollment in medical assistance, the commissioner shall
207.5 require that a high-risk provider, or a person with a direct or indirect ownership interest in
207.6 the provider of five percent or higher, consent to criminal background checks, including
207.7 fingerprinting, when required to do so under state law or by a determination by the
207.8 commissioner or the Centers for Medicare and Medicaid Services that a provider is
207.9 designated high-risk for fraud, waste, or abuse.

207.10 (g) As a condition of enrollment, all durable medical equipment, prosthetics,
207.11 orthotics, and supplies (DMEPOS) suppliers operating in Minnesota are required to name
207.12 the Department of Human Services, in addition to the Centers for Medicare and Medicaid
207.13 Services, as an obligee on all surety performance bonds required pursuant to section
207.14 4312(a) of the Balanced Budget Act of 1997, Public Law 105-33, amending Social
207.15 Security Act, section 1834(a). The performance bond must also allow for recovery of
207.16 costs and fees in pursuing a claim on the bond.

207.17 (h) The Department of Human Services may require a provider to purchase a
207.18 performance surety bond as a condition of initial enrollment, reenrollment, reinstatement,
207.19 or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the
207.20 department determines there is significant evidence of or potential for fraud and abuse by
207.21 the provider, or (3) the provider or category of providers is designated high-risk pursuant
207.22 to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450, or the
207.23 department otherwise finds it is in the best interest of the Medicaid program to do so. The
207.24 performance bond must be in an amount of $100,000 or ten percent of the provider's
207.25 payments from Medicaid during the immediately preceding 12 months, whichever is
207.26 greater. The performance bond must name the Department of Human Services as an
207.27 obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

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

207.29 Sec. 6. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision
207.30 to read:

207.31 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
207.32 required nonrefundable application fees to pay for provider screening activities in
207.33 accordance with Code of Federal Regulations, title 42, section 455, subpart E. The
207.34 enrollment application must be made under the procedures specified by the commissioner,
207.35 in the form specified by the commissioner, and accompanied by an application fee

208.1 described in paragraph (b), or a request for a hardship exception as described in the
208.2 specified procedures. Application fees must be deposited in the provider screening account
208.3 in the special revenue fund. Amounts in the provider screening account are appropriated
208.4 to the commissioner for costs associated with the provider screening activities required
208.5 in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner
208.6 shall conduct screening activities as required by Code of Federal Regulations, title 42,
208.7 section 455, subpart E, and as otherwise provided by law, to include database checks,
208.8 unannounced pre- and postenrollment site visits, fingerprinting, and criminal background
208.9 studies. The commissioner must revalidate all providers under this subdivision at least
208.10 once every five years.

208.11 (b) The application fee under this subdivision is $532 for the calendar year 2013.
208.12 For calendar year 2014 and subsequent years, the fee:

208.13 (1) is adjusted by the percentage change to the consumer price index for all urban
208.14 consumers, United States city average, for the 12-month period ending with June of the
208.15 previous year. The resulting fee must be announced in the Federal Register;

208.16 (2) is effective from January 1 to December 31 of a calendar year;

208.17 (3) is required on the submission of an initial application, an application to establish
208.18 a new practice location, an application for re-enrollment when the provider is not enrolled
208.19 at the time of application of re-enrollment, or at revalidation when required by federal
208.20 regulation; and

208.21 (4) must be in the amount in effect for the calendar year during which the application
208.22 for enrollment, new practice location, or re-enrollment is being submitted.

208.23 (c) The application fee under this subdivision cannot be charged to:

208.24 (1) providers who are enrolled in Medicare or who provide documentation of
208.25 payment of the fee to, and enrollment with, another state;

208.26 (2) providers who are enrolled but are required to submit new applications for
208.27 purposes of re-enrollment; or

208.28 (3) a provider who enrolls as an individual.

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

208.30 Sec. 7. Minnesota Statutes 2012, section 256B.064, subdivision 1a, is amended to read:

208.31 Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may
208.32 impose sanctions against a vendor of medical care for any of the following: (1) fraud,
208.33 theft, or abuse in connection with the provision of medical care to recipients of public
208.34 assistance; (2) a pattern of presentment of false or duplicate claims or claims for services
208.35 not medically necessary; (3) a pattern of making false statements of material facts for

209.1 the purpose of obtaining greater compensation than that to which the vendor is legally
209.2 entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state
209.3 agency access during regular business hours to examine all records necessary to disclose
209.4 the extent of services provided to program recipients and appropriateness of claims for
209.5 payment; (6) failure to repay an overpayment or a fine finally established under this
209.6 section; ~~and~~ (7) failure to correct errors in the maintenance of health service or financial
209.7 records for which a fine was imposed or after issuance of a warning by the commissioner;
209.8 and (8) any reason for which a vendor could be excluded from participation in the
209.9 Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.
209.10 The determination of services not medically necessary may be made by the commissioner
209.11 in consultation with a peer advisory task force appointed by the commissioner on the
209.12 recommendation of appropriate professional organizations. The task force expires as
209.13 provided in section 15.059, subdivision 5.

209.14 Sec. 8. Minnesota Statutes 2012, section 256B.064, subdivision 1b, is amended to read:
209.15 Subd. 1b. **Sanctions available.** The commissioner may impose the following
209.16 sanctions for the conduct described in subdivision 1a: suspension or withholding of
209.17 payments to a vendor and suspending or terminating participation in the program, or
209.18 imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under
209.19 this section, the commissioner shall consider the nature, chronicity, or severity of the
209.20 conduct and the effect of the conduct on the health and safety of persons served by the
209.21 vendor. Regardless of imposition of sanctions, the commissioner may make a referral
209.22 to the appropriate state licensing board.

209.23 Sec. 9. Minnesota Statutes 2012, section 256B.064, subdivision 2, is amended to read:
209.24 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner
209.25 shall determine any monetary amounts to be recovered and sanctions to be imposed upon
209.26 a vendor of medical care under this section. Except as provided in paragraphs (b) and
209.27 (d), neither a monetary recovery nor a sanction will be imposed by the commissioner
209.28 without prior notice and an opportunity for a hearing, according to chapter 14, on the
209.29 commissioner's proposed action, provided that the commissioner may suspend or reduce
209.30 payment to a vendor of medical care, except a nursing home or convalescent care facility,
209.31 after notice and prior to the hearing if in the commissioner's opinion that action is
209.32 necessary to protect the public welfare and the interests of the program.
209.33 (b) Except when the commissioner finds good cause not to suspend payments under
209.34 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall

210.1 withhold or reduce payments to a vendor of medical care without providing advance
210.2 notice of such withholding or reduction if either of the following occurs:
210.3 (1) the vendor is convicted of a crime involving the conduct described in subdivision
210.4 1a; or
210.5 (2) the commissioner determines there is a credible allegation of fraud for which an
210.6 investigation is pending under the program. A credible allegation of fraud is an allegation
210.7 which has been verified by the state, from any source, including but not limited to:
210.8 (i) fraud hotline complaints;
210.9 (ii) claims data mining; and
210.10 (iii) patterns identified through provider audits, civil false claims cases, and law
210.11 enforcement investigations.
210.12 Allegations are considered to be credible when they have an indicia of reliability
210.13 and the state agency has reviewed all allegations, facts, and evidence carefully and acts
210.14 judiciously on a case-by-case basis.
210.15 (c) The commissioner must send notice of the withholding or reduction of payments
210.16 under paragraph (b) within five days of taking such action unless requested in writing by a
210.17 law enforcement agency to temporarily withhold the notice. The notice must:
210.18 (1) state that payments are being withheld according to paragraph (b);
210.19 (2) set forth the general allegations as to the nature of the withholding action, but
210.20 need not disclose any specific information concerning an ongoing investigation;
210.21 (3) except in the case of a conviction for conduct described in subdivision 1a, state
210.22 that the withholding is for a temporary period and cite the circumstances under which
210.23 withholding will be terminated;
210.24 (4) identify the types of claims to which the withholding applies; and
210.25 (5) inform the vendor of the right to submit written evidence for consideration by
210.26 the commissioner.
210.27 The withholding or reduction of payments will not continue after the commissioner
210.28 determines there is insufficient evidence of fraud by the vendor, or after legal proceedings
210.29 relating to the alleged fraud are completed, unless the commissioner has sent notice of
210.30 intention to impose monetary recovery or sanctions under paragraph (a).
210.31 (d) The commissioner shall suspend or terminate a vendor's participation in the
210.32 program without providing advance notice and an opportunity for a hearing when the
210.33 suspension or termination is required because of the vendor's exclusion from participation
210.34 in Medicare. Within five days of taking such action, the commissioner must send notice of
210.35 the suspension or termination. The notice must:

211.1 (1) state that suspension or termination is the result of the vendor's exclusion from
211.2 Medicare;
211.3 (2) identify the effective date of the suspension or termination; and
211.4 (3) inform the vendor of the need to be reinstated to Medicare before reapplying
211.5 for participation in the program.
211.6 (e) Upon receipt of a notice under paragraph (a) that a monetary recovery or
211.7 sanction is to be imposed, a vendor may request a contested case, as defined in section
211.8 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The
211.9 appeal request must be received by the commissioner no later than 30 days after the date
211.10 the notification of monetary recovery or sanction was mailed to the vendor. The appeal
211.11 request must specify:
211.12 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
211.13 amount involved for each disputed item;
211.14 (2) the computation that the vendor believes is correct;
211.15 (3) the authority in statute or rule upon which the vendor relies for each disputed item;
211.16 (4) the name and address of the person or entity with whom contacts may be made
211.17 regarding the appeal; and
211.18 (5) other information required by the commissioner.
211.19 (f) The commissioner may order a vendor to forfeit a fine for failure to fully
211.20 document services according to standards in this chapter and Minnesota Rules, chapter
211.21 9505. Fines may be assessed when the commissioner has no evidence that services were
211.22 not provided and services are partially documented in the health service or financial
211.23 record, but specific required components of documentation are missing. The fine for
211.24 incomplete documentation shall equal 20 percent of the amount paid on the claims for
211.25 reimbursement submitted by the vendor, or up to $5,000, whichever is less.
211.26 (g) The vendor shall pay the fine assessed on or before the payment date specified. If
211.27 the vendor fails to pay the fine, the commissioner may withhold or reduce payments and
211.28 recover the amount of the fine. A timely appeal shall stay payment of the fine until the
211.29 commissioner issues a final order.

211.30 Sec. 10. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to
211.31 read:
211.32 Subd. 21. **Requirements for initial enrollment of personal care assistance**
211.33 **provider agencies.** (a) All personal care assistance provider agencies must provide, at the
211.34 time of enrollment as a personal care assistance provider agency in a format determined

212.1 by the commissioner, information and documentation that includes, but is not limited to,
212.2 the following:
212.3 (1) the personal care assistance provider agency's current contact information
212.4 including address, telephone number, and e-mail address;
212.5 (2) proof of surety bond coverage in the amount of ~~$50,000~~ $100,000 or ten percent
212.6 of the provider's payments from Medicaid in the previous year, whichever is ~~less~~ more.
212.7 The performance bond must be in a form approved by the commissioner, must be renewed
212.8 annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;
212.9 (3) proof of fidelity bond coverage in the amount of $20,000;
212.10 (4) proof of workers' compensation insurance coverage;
212.11 (5) proof of liability insurance;
212.12 (6) a description of the personal care assistance provider agency's organization
212.13 identifying the names of all owners, managing employees, staff, board of directors, and
212.14 the affiliations of the directors, owners, or staff to other service providers;
212.15 (7) a copy of the personal care assistance provider agency's written policies and
212.16 procedures including: hiring of employees; training requirements; service delivery;
212.17 and employee and consumer safety including process for notification and resolution
212.18 of consumer grievances, identification and prevention of communicable diseases, and
212.19 employee misconduct;
212.20 (8) copies of all other forms the personal care assistance provider agency uses in
212.21 the course of daily business including, but not limited to:
212.22 (i) a copy of the personal care assistance provider agency's time sheet if the time
212.23 sheet varies from the standard time sheet for personal care assistance services approved
212.24 by the commissioner, and a letter requesting approval of the personal care assistance
212.25 provider agency's nonstandard time sheet;
212.26 (ii) the personal care assistance provider agency's template for the personal care
212.27 assistance care plan; and
212.28 (iii) the personal care assistance provider agency's template for the written
212.29 agreement in subdivision 20 for recipients using the personal care assistance choice
212.30 option, if applicable;
212.31 (9) a list of all training and classes that the personal care assistance provider agency
212.32 requires of its staff providing personal care assistance services;
212.33 (10) documentation that the personal care assistance provider agency and staff have
212.34 successfully completed all the training required by this section;
212.35 (11) documentation of the agency's marketing practices;

213.1 (12) disclosure of ownership, leasing, or management of all residential properties
213.2 that is used or could be used for providing home care services;
213.3 (13) documentation that the agency will use the following percentages of revenue
213.4 generated from the medical assistance rate paid for personal care assistance services
213.5 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
213.6 personal care assistance choice option and 72.5 percent of revenue from other personal
213.7 care assistance providers. The revenue generated by the qualified professional and the
213.8 reasonable costs associated with the qualified professional shall not be used in making
213.9 this calculation; and
213.10 (14) effective May 15, 2010, documentation that the agency does not burden
213.11 recipients' free exercise of their right to choose service providers by requiring personal
213.12 care assistants to sign an agreement not to work with any particular personal care
213.13 assistance recipient or for another personal care assistance provider agency after leaving
213.14 the agency and that the agency is not taking action on any such agreements or requirements
213.15 regardless of the date signed.
213.16 (b) Personal care assistance provider agencies shall provide the information specified
213.17 in paragraph (a) to the commissioner at the time the personal care assistance provider
213.18 agency enrolls as a vendor or upon request from the commissioner. The commissioner
213.19 shall collect the information specified in paragraph (a) from all personal care assistance
213.20 providers beginning July 1, 2009.
213.21 (c) All personal care assistance provider agencies shall require all employees in
213.22 management and supervisory positions and owners of the agency who are active in the
213.23 day-to-day management and operations of the agency to complete mandatory training
213.24 as determined by the commissioner before enrollment of the agency as a provider.
213.25 Employees in management and supervisory positions and owners who are active in
213.26 the day-to-day operations of an agency who have completed the required training as
213.27 an employee with a personal care assistance provider agency do not need to repeat
213.28 the required training if they are hired by another agency, if they have completed the
213.29 training within the past three years. By September 1, 2010, the required training must
213.30 be available with meaningful access according to title VI of the Civil Rights Act and
213.31 federal regulations adopted under that law or any guidance from the United States Health
213.32 and Human Services Department. The required training must be available online or by
213.33 electronic remote connection. The required training must provide for competency testing.
213.34 Personal care assistance provider agency billing staff shall complete training about
213.35 personal care assistance program financial management. This training is effective July 1,
213.36 2009. Any personal care assistance provider agency enrolled before that date shall, if it

214.1 has not already, complete the provider training within 18 months of July 1, 2009. Any new
214.2 owners or employees in management and supervisory positions involved in the day-to-day
214.3 operations are required to complete mandatory training as a requisite of working for the
214.4 agency. Personal care assistance provider agencies certified for participation in Medicare
214.5 as home health agencies are exempt from the training required in this subdivision. When
214.6 available, Medicare-certified home health agency owners, supervisors, or managers must
214.7 successfully complete the competency test.

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

214.9 ## ARTICLE 6

214.10 ## 2013 MANAGED CARE ORGANIZATIONS RATE CONFORMITY

214.11 Section 1. Minnesota Statutes 2012, section 256.969, subdivision 3a, is amended to read:
214.12 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
214.13 assistance program must not be submitted until the recipient is discharged. However,
214.14 the commissioner shall establish monthly interim payments for inpatient hospitals that
214.15 have individual patient lengths of stay over 30 days regardless of diagnostic category.
214.16 Except as provided in section 256.9693, medical assistance reimbursement for treatment
214.17 of mental illness shall be reimbursed based on diagnostic classifications. Individual
214.18 hospital payments established under this section and sections 256.9685, 256.9686, and
214.19 256.9695, in addition to third-party and recipient liability, for discharges occurring during
214.20 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
214.21 inpatient services paid for the same period of time to the hospital. This payment limitation
214.22 shall be calculated separately for medical assistance and general assistance medical
214.23 care services. The limitation on general assistance medical care shall be effective for
214.24 admissions occurring on or after July 1, 1991. Services that have rates established under
214.25 subdivision 11 or 12, must be limited separately from other services. After consulting with
214.26 the affected hospitals, the commissioner may consider related hospitals one entity and
214.27 may merge the payment rates while maintaining separate provider numbers. The operating
214.28 and property base rates per admission or per day shall be derived from the best Medicare
214.29 and claims data available when rates are established. The commissioner shall determine
214.30 the best Medicare and claims data, taking into consideration variables of recency of the
214.31 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
214.32 The commissioner shall notify hospitals of payment rates by December 1 of the year
214.33 preceding the rate year. The rate setting data must reflect the admissions data used to
214.34 establish relative values. Base year changes from 1981 to the base year established for the

215.1 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
215.2 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
215.3 1. The commissioner may adjust base year cost, relative value, and case mix index data
215.4 to exclude the costs of services that have been discontinued by the October 1 of the year
215.5 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
215.6 that encompass portions of two or more rate years shall have payments established based
215.7 on payment rates in effect at the time of admission unless the date of admission preceded
215.8 the rate year in effect by six months or more. In this case, operating payment rates for
215.9 services rendered during the rate year in effect and established based on the date of
215.10 admission shall be adjusted to the rate year in effect by the hospital cost index.

215.11 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
215.12 payment, before third-party liability and spenddown, made to hospitals for inpatient
215.13 services is reduced by .5 percent from the current statutory rates.

215.14 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
215.15 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services
215.16 before third-party liability and spenddown, is reduced five percent from the current
215.17 statutory rates. Mental health services within diagnosis related groups 424 to 432, and
215.18 facilities defined under subdivision 16 are excluded from this paragraph.

215.19 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
215.20 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
215.21 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
215.22 from the current statutory rates. Mental health services within diagnosis related groups
215.23 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
215.24 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
215.25 assistance does not include general assistance medical care. Payments made to managed
215.26 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
215.27 this reduction.

215.28 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
215.29 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
215.30 to hospitals for inpatient services before third-party liability and spenddown, is reduced
215.31 3.46 percent from the current statutory rates. Mental health services with diagnosis related
215.32 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
215.33 paragraph. Payments made to managed care plans shall be reduced for services provided
215.34 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

215.35 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
215.36 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made

216.1 to hospitals for inpatient services before third-party liability and spenddown, is reduced
216.2 1.9 percent from the current statutory rates. Mental health services with diagnosis related
216.3 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
216.4 paragraph. Payments made to managed care plans shall be reduced for services provided
216.5 on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

216.6 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
216.7 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
216.8 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
216.9 from the current statutory rates. Mental health services with diagnosis related groups
216.10 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
216.11 Payments made to managed care plans shall be reduced for services provided on or after
216.12 July 1, 2011, to reflect this reduction.

216.13 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
216.14 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
216.15 hospitals for inpatient services before third-party liability and spenddown, is reduced
216.16 one percent from the current statutory rates. Facilities defined under subdivision 16 are
216.17 excluded from this paragraph. Payments made to managed care plans shall be reduced for
216.18 services provided on or after October 1, 2009, to reflect this reduction.

216.19 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
216.20 payment for fee-for-service admissions occurring on or after July 1, 2011, made to
216.21 hospitals for inpatient services before third-party liability and spenddown, is reduced
216.22 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are
216.23 excluded from this paragraph. Payments made to managed care plans shall be reduced for
216.24 services provided on or after January 1, 2011, to reflect this reduction.

216.25 (j) For admissions occurring on or after January 1, 2014, the rate for inpatient
216.26 hospital services must be increased two percent from the rate in effect on December 31,
216.27 2013. Payments made to managed care plans shall not be adjusted to reflect payments
216.28 under this paragraph.

216.29 Sec. 2. Minnesota Statutes 2012, section 256B.0625, subdivision 17a, is amended to
216.30 read:

216.31 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers
216.32 ambulance services. Providers shall bill ambulance services according to Medicare
216.33 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective
216.34 for services rendered on or after July 1, 2001, medical assistance payments for ambulance

217.1 services shall be paid at the Medicare reimbursement rate or at the medical assistance
217.2 payment rate in effect on July 1, 2000, whichever is greater.

217.3 (b) Effective for services provided on or after September 1, 2011, ambulance
217.4 services payment rates are reduced 4.5 percent. Payments made to managed care plans
217.5 and county-based purchasing plans must be reduced for services provided on or after
217.6 January 1, 2012, to reflect this reduction.

217.7 (c) Effective for services provided on or after January 1, 2014, ambulance services
217.8 payment rates are increased by three percent over the rates in effect on December 31,
217.9 2013. Payments made to managed care plans shall not be adjusted to reflect payments
217.10 under this paragraph.

217.11 Sec. 3. Minnesota Statutes 2012, section 256B.69, subdivision 5c, is amended to read:

217.12 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
217.13 services shall transfer each year to the medical education and research fund established
217.14 under section 62J.692, an amount specified in this subdivision. The commissioner shall
217.15 calculate the following:

217.16 (1) an amount equal to the reduction in the prepaid medical assistance payments as
217.17 specified in this clause. Until January 1, 2002, the county medical assistance capitation
217.18 base rate prior to plan specific adjustments and after the regional rate adjustments under
217.19 subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining
217.20 metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after
217.21 January 1, 2002, the county medical assistance capitation base rate prior to plan specific
217.22 adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining
217.23 metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing
217.24 facility and elderly waiver payments and demonstration project payments operating
217.25 under subdivision 23 are excluded from this reduction. The amount calculated under
217.26 this clause shall not be adjusted for periods already paid due to subsequent changes to
217.27 the capitation payments;

217.28 (2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this
217.29 section;

217.30 (3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates
217.31 paid under this section; and

217.32 (4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid
217.33 under this section.

217.34 (b) This subdivision shall be effective upon approval of a federal waiver which
217.35 allows federal financial participation in the medical education and research fund. The

218.1 amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount
218.2 transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under
218.3 paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally
218.4 reduce the amount specified under paragraph (a), clause (1).

218.5 (c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner
218.6 shall transfer $21,714,000 each fiscal year to the medical education and research fund.

218.7 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the
218.8 transfer under paragraph (c), the commissioner shall transfer to the medical education
218.9 research fund $23,936,000 in fiscal years 2012 and 2013 and ~~$36,744,000~~ $49,552,000 in
218.10 fiscal year 2014 and thereafter.

218.11 Sec. 4. Minnesota Statutes 2012, section 256B.69, subdivision 31, is amended to read:

218.12 Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner
218.13 shall reduce payments and limit future rate increases paid to managed care plans and
218.14 county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved
218.15 on a statewide aggregate basis by program. The commissioner may use competitive
218.16 bidding, payment reductions, or other reductions to achieve the reductions and limits
218.17 in this subdivision.

218.18 (b) Beginning September 1, 2011, the commissioner shall reduce payments to
218.19 managed care plans and county-based purchasing plans as follows:

218.20 (1) 2.0 percent for medical assistance elderly basic care. This shall not apply
218.21 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
218.22 services;

218.23 (2) 2.82 percent for medical assistance families and children;

218.24 (3) 10.1 percent for medical assistance adults without children; and

218.25 (4) 6.0 percent for MinnesotaCare families and children.

218.26 (c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed
218.27 care plans and county-based purchasing plans for calendar year 2012 to a percentage of
218.28 the rates in effect on August 31, 2011, as follows:

218.29 (1) 98 percent for medical assistance elderly basic care. This shall not apply to
218.30 Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
218.31 services;

218.32 (2) 97.18 percent for medical assistance families and children;

218.33 (3) 89.9 percent for medical assistance adults without children; and

218.34 (4) 94 percent for MinnesotaCare families and children.

219.1 (d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit
219.2 the maximum annual trend ~~increases~~ changes to rates paid to managed care plans and
219.3 county-based purchasing plans as follows:
219.4 (1) ~~7.5~~ 5.4 percent for medical assistance elderly basic care. This shall not apply
219.5 to ~~Medicare cost-sharing, nursing facility, personal care assistance, and~~ elderly waiver
219.6 services;
219.7 (2) ~~5.0~~ 0.0 percent for medical assistance special needs basic care;
219.8 (3) ~~2.0~~ 0.0 percent for medical assistance families and children;
219.9 (4) ~~3.0~~ -5.1 percent for medical assistance adults without children;
219.10 (5) ~~3.0~~ 2.7 percent for MinnesotaCare families and children; and
219.11 (6) ~~3.0~~ 11.4 percent for MinnesotaCare adults without children.
219.12 (e) The commissioner may limit trend increases to less than the maximum.
219.13 Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases
219.14 to rates paid to managed care plans and county-based purchasing plans as follows for
219.15 calendar years 2014 and 2015:
219.16 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply
219.17 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
219.18 services;
219.19 (2) 5.0 percent for medical assistance special needs basic care;
219.20 (3) 2.0 percent for medical assistance families and children;
219.21 (4) 3.0 percent for medical assistance adults without children;
219.22 (5) 3.0 percent for MinnesotaCare families and children; and
219.23 (6) 4.0 percent for MinnesotaCare adults without children.
219.24 The commissioner may limit trend increases to less than the maximum.

219.25 Sec. 5. Minnesota Statutes 2012, section 256B.76, subdivision 1, is amended to read:
219.26 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
219.27 or after October 1, 1992, the commissioner shall make payments for physician services
219.28 as follows:
219.29 (1) payment for level one Centers for Medicare and Medicaid Services' common
219.30 procedural coding system codes titled "office and other outpatient services," "preventive
219.31 medicine new and established patient," "delivery, antepartum, and postpartum care,"
219.32 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
219.33 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
219.34 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
219.35 30, 1992. If the rate on any procedure code within these categories is different than the

220.1 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
220.2 then the larger rate shall be paid;

220.3 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
220.4 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

220.5 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
220.6 percentile of 1989, less the percent in aggregate necessary to equal the above increases
220.7 except that payment rates for home health agency services shall be the rates in effect
220.8 on September 30, 1992.

220.9 (b) Effective for services rendered on or after January 1, 2000, payment rates for
220.10 physician and professional services shall be increased by three percent over the rates
220.11 in effect on December 31, 1999, except for home health agency and family planning
220.12 agency services. The increases in this paragraph shall be implemented January 1, 2000,
220.13 for managed care.

220.14 (c) Effective for services rendered on or after July 1, 2009, payment rates for
220.15 physician and professional services shall be reduced by five percent, except that for the
220.16 period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent
220.17 for the medical assistance and general assistance medical care programs, over the rates in
220.18 effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply
220.19 to office or other outpatient visits, preventive medicine visits and family planning visits
220.20 billed by physicians, advanced practice nurses, or physician assistants in a family planning
220.21 agency or in one of the following primary care practices: general practice, general internal
220.22 medicine, general pediatrics, general geriatrics, and family medicine. This reduction
220.23 and the reductions in paragraph (d) do not apply to federally qualified health centers,
220.24 rural health centers, and Indian health services. Effective October 1, 2009, payments
220.25 made to managed care plans and county-based purchasing plans under sections 256B.69,
220.26 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

220.27 (d) Effective for services rendered on or after July 1, 2010, payment rates for
220.28 physician and professional services shall be reduced an additional seven percent over
220.29 the five percent reduction in rates described in paragraph (c). This additional reduction
220.30 does not apply to physical therapy services, occupational therapy services, and speech
220.31 pathology and related services provided on or after July 1, 2010. This additional reduction
220.32 does not apply to physician services billed by a psychiatrist or an advanced practice nurse
220.33 with a specialty in mental health. Effective October 1, 2010, payments made to managed
220.34 care plans and county-based purchasing plans under sections 256B.69, 256B.692, and
220.35 256L.12 shall reflect the payment reduction described in this paragraph.

221.1 (e) Effective for services rendered on or after September 1, 2011, through June 30,
221.2 2013, payment rates for physician and professional services shall be reduced three percent
221.3 from the rates in effect on August 31, 2011. This reduction does not apply to physical
221.4 therapy services, occupational therapy services, and speech pathology and related services.
221.5 (f) Effective for services rendered on or after January 1, 2014, payment rates for
221.6 physician and professional services, including physical therapy, occupational therapy,
221.7 speech pathology, and mental health services shall be increased by five percent from the
221.8 rates in effect on December 31, 2013. This increase does not apply to federally qualified
221.9 health centers, rural health centers, and Indian health services. Payments made to managed
221.10 care plans shall not be adjusted to reflect payments under this paragraph.

221.11 Sec. 6. Minnesota Statutes 2012, section 256B.76, subdivision 2, is amended to read:
221.12 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after
221.13 October 1, 1992, the commissioner shall make payments for dental services as follows:
221.14 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
221.15 percent above the rate in effect on June 30, 1992; and
221.16 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
221.17 percentile of 1989, less the percent in aggregate necessary to equal the above increases.
221.18 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
221.19 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.
221.20 (c) Effective for services rendered on or after January 1, 2000, payment rates for
221.21 dental services shall be increased by three percent over the rates in effect on December
221.22 31, 1999.
221.23 (d) Effective for services provided on or after January 1, 2002, payment for
221.24 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
221.25 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.
221.26 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
221.27 2000, for managed care.
221.28 (f) Effective for dental services rendered on or after October 1, 2010, by a
221.29 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based
221.30 on the Medicare principles of reimbursement. This payment shall be effective for services
221.31 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
221.32 county-based purchasing plans.
221.33 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
221.34 in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal
221.35 year, a supplemental state payment equal to the difference between the total payments

222.1 in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated
222.2 services for the operation of the dental clinics.

222.3 (h) If the cost-based payment system for state-operated dental clinics described in
222.4 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
222.5 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
222.6 receive the critical access dental reimbursement rate as described under subdivision 4,
222.7 paragraph (a).

222.8 (i) Effective for services rendered on or after September 1, 2011, through June 30,
222.9 2013, payment rates for dental services shall be reduced by three percent. This reduction
222.10 does not apply to state-operated dental clinics in paragraph (f).

222.11 (j) Effective for services rendered on or after January 1, 2014, payment rates for
222.12 dental services shall be increased by five percent from the rates in effect on December
222.13 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),
222.14 federally qualified health centers, rural health centers, and Indian health services. Effective
222.15 January 1, 2014, payments made to managed care plans and county-based purchasing
222.16 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
222.17 described in this paragraph.

222.18 Sec. 7. Minnesota Statutes 2012, section 256B.761, is amended to read:

222.19 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

222.20 (a) Effective for services rendered on or after July 1, 2001, payment for medication
222.21 management provided to psychiatric patients, outpatient mental health services, day
222.22 treatment services, home-based mental health services, and family community support
222.23 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
222.24 50th percentile of 1999 charges.

222.25 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
222.26 services provided by an entity that operates: (1) a Medicare-certified comprehensive
222.27 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
222.28 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
222.29 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
222.30 when those services are provided within the comprehensive outpatient rehabilitation
222.31 facility and provided to residents of nursing facilities owned by the entity.

222.32 (c) The commissioner shall establish three levels of payment for mental health
222.33 diagnostic assessment, based on three levels of complexity. The aggregate payment under
222.34 the tiered rates must not exceed the projected aggregate payments for mental health

223.1 diagnostic assessment under the previous single rate. The new rate structure is effective
223.2 January 1, 2011, or upon federal approval, whichever is later.
223.3 (d) Effective for services rendered on or after January 1, 2014, payment rates for
223.4 outpatient mental health services shall be increased by five percent over the rates in effect
223.5 on December 31, 2013. Payments made to managed care plans shall not be adjusted
223.6 to reflect payments under this paragraph.

223.7 Sec. 8. Minnesota Statutes 2012, section 256B.766, is amended to read:

223.8 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

223.9 (a) Effective for services provided on or after July 1, 2009, total payments for basic
223.10 care services, shall be reduced by three percent, except that for the period July 1, 2009,
223.11 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
223.12 assistance and general assistance medical care programs, prior to third-party liability and
223.13 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
223.14 therapy services, occupational therapy services, and speech-language pathology and
223.15 related services as basic care services. The reduction in this paragraph shall apply to
223.16 physical therapy services, occupational therapy services, and speech-language pathology
223.17 and related services provided on or after July 1, 2010.
223.18 (b) Payments made to managed care plans and county-based purchasing plans shall
223.19 be reduced for services provided on or after October 1, 2009, to reflect the reduction
223.20 effective July 1, 2009, and payments made to the plans shall be reduced effective October
223.21 1, 2010, to reflect the reduction effective July 1, 2010.
223.22 (c) Effective for services provided on or after September 1, 2011, through June 30,
223.23 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
223.24 from the rates in effect on August 31, 2011.
223.25 (d) Effective for services provided on or after September 1, 2011, through June
223.26 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
223.27 and durable medical equipment not subject to a volume purchase contract, prosthetics
223.28 and orthotics, renal dialysis services, laboratory services, public health nursing services,
223.29 physical therapy services, occupational therapy services, speech therapy services,
223.30 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
223.31 purchase contract, and anesthesia services~~, and hospice services~~ shall be reduced by three
223.32 percent from the rates in effect on August 31, 2011.
223.33 (e) Effective for services provided on or after January 1, 2014, payments for
223.34 ambulatory surgery centers facility fees, medical supplies and durable medical equipment
223.35 not subject to a volume purchase contract, prosthetics and orthotics, hospice services,

224.1 renal dialysis services, laboratory services, public health nursing services, eyeglasses not
224.2 subject to a volume purchase contract, and hearing aids not subject to a volume purchase
224.3 contract shall be increased by three percent and payments for outpatient hospital facility
224.4 fees shall be increased by five percent. Payments made to managed care plans shall not be
224.5 adjusted to reflect payments under this paragraph.

224.6 ~~(e)~~ (f) This section does not apply to physician and professional services, inpatient
224.7 hospital services, family planning services, mental health services, dental services,
224.8 prescription drugs, medical transportation, federally qualified health centers, rural health
224.9 centers, Indian health services, and Medicare cost-sharing.

224.10 **ARTICLE 7**

224.11 **HEALTH CARE**

224.12 Section 1. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

224.34 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
224.35 States Attorney General according to the Illegal Immigration Reform and Immigrant

225.1 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
225.2 Public Law 104-200; or

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

225.5 (c) All qualified noncitizens who were residing in the United States before August
225.6 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
225.7 medical assistance with federal financial participation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) services for routine prenatal care;

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

(v) elective surgery;

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

(vii) preventative health care and family planning services;

~~(viii) dialysis;~~

~~(ix) chemotherapy or therapeutic radiation services;~~

~~(x)~~ (viii) rehabilitation services;

~~(xi)~~ (ix) physical, occupational, or speech therapy;

~~(xii)~~ (x) transportation services;

~~(xiii)~~ (xi) case management;

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

~~(xv)~~ (xiii) dental services;

~~(xvi)~~ (xiv) hospice care;

~~(xvii)~~ (xv) audiology services and hearing aids;

~~(xviii)~~ (xvi) podiatry services;

~~(xix)~~ (xvii) chiropractic services;

227.1 ~~(xx)~~ (xviii) immunizations;

227.2 ~~(xxi)~~ (xix) vision services and eyeglasses;

227.3 ~~(xxii)~~ (xx) waiver services;

227.4 ~~(xxiii)~~ (xxi) individualized education programs; or

227.5 ~~(xxiv)~~ (xxii) chemical dependency treatment.

227.6 (i) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
227.7 nonimmigrants, or lawfully present in the United States as defined in Code of Federal
227.8 Regulations, title 8, section 103.12, are not covered by a group health plan or health
227.9 insurance coverage according to Code of Federal Regulations, title 42, section 457.310,
227.10 and who otherwise meet the eligibility requirements of this chapter, are eligible for
227.11 medical assistance through the period of pregnancy, including labor and delivery, and 60
227.12 days postpartum, to the extent federal funds are available under title XXI of the Social
227.13 Security Act, and the state children's health insurance program.

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

227.20 (k) Notwithstanding paragraph (h), clause (2), the following services are covered as
227.21 emergency medical conditions under paragraph (f) except where coverage is prohibited
227.22 under federal law:

227.23 (1) dialysis services provided in a hospital or freestanding dialysis facility; and

227.24 (2) surgery and the administration of chemotherapy, radiation, and related services
227.25 necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission
227.26 and requires surgery, chemotherapy, or radiation treatment.

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

227.28 Sec. 2. Minnesota Statutes 2012, section 256B.0625, subdivision 13e, is amended to
227.29 read:

227.30 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
227.31 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable
227.32 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price
227.33 charged to the public. The amount of payment basis must be reduced to reflect all discount
227.34 amounts applied to the charge by any provider/insurer agreement or contract for submitted
227.35 charges to medical assistance programs. The net submitted charge may not be greater

228.1 than the patient liability for the service. The pharmacy dispensing fee shall be $3.65,
228.2 except that the dispensing fee for intravenous solutions which must be compounded by
228.3 the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and
228.4 $30 per bag for total parenteral nutritional products dispensed in one liter quantities,
228.5 or $44 per bag for total parenteral nutritional products dispensed in quantities greater
228.6 than one liter. Actual acquisition cost includes quantity and other special discounts
228.7 except time and cash discounts. The actual acquisition cost of a drug shall be estimated
228.8 by the commissioner at wholesale acquisition cost plus four percent for independently
228.9 owned pharmacies located in a designated rural area within Minnesota, and at wholesale
228.10 acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently
228.11 owned" if it is one of four or fewer pharmacies under the same ownership nationally.
228.12 A "designated rural area" means an area defined as a small rural area or isolated rural
228.13 area according to the four-category classification of the Rural Urban Commuting Area
228.14 system developed for the United States Health Resources and Services Administration.
228.15 The actual acquisition cost of a drug acquired through the federal 340B Drug Pricing
228.16 Program shall be estimated by the commissioner at wholesale acquisition cost minus 44
228.17 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or
228.18 biological to wholesalers or direct purchasers in the United States, not including prompt
228.19 pay or other discounts, rebates, or reductions in price, for the most recent month for which
228.20 information is available, as reported in wholesale price guides or other publications of
228.21 drug or biological pricing data. The maximum allowable cost of a multisource drug may
228.22 be set by the commissioner and it shall be comparable to, but no higher than, the maximum
228.23 amount paid by other third-party payors in this state who have maximum allowable cost
228.24 programs. Establishment of the amount of payment for drugs shall not be subject to the
228.25 requirements of the Administrative Procedure Act.

228.26 (b) An additional dispensing fee of $.30 may be added to the dispensing fee paid
228.27 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
228.28 facilities when a unit dose blister card system, approved by the department, is used. Under
228.29 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The
228.30 National Drug Code (NDC) from the drug container used to fill the blister card must be
228.31 identified on the claim to the department. The unit dose blister card containing the drug
228.32 must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that
228.33 govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will
228.34 be required to credit the department for the actual acquisition cost of all unused drugs that
228.35 are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in
228.36 a quantity that is less than a 30-day supply.

229.1 (c) Whenever a maximum allowable cost has been set for a multisource drug,
229.2 payment shall be the lower of the usual and customary price charged to the public or the
229.3 maximum allowable cost established by the commissioner unless prior authorization
229.4 for the brand name product has been granted according to the criteria established by
229.5 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the
229.6 prescriber has indicated "dispense as written" on the prescription in a manner consistent
229.7 with section 151.21, subdivision 2.

229.8 (d) The basis for determining the amount of payment for drugs administered in an
229.9 outpatient setting shall be the lower of the usual and customary cost submitted by the
229.10 provider ~~or~~, 106 percent of the average sales price as determined by the United States
229.11 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
229.12 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
229.13 set by the commissioner. If average sales price is unavailable, the amount of payment
229.14 must be lower of the usual and customary cost submitted by the provider ~~or~~, the wholesale
229.15 acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the
229.16 commissioner. The commissioner shall discount the payment rate for drugs obtained
229.17 through the federal 340B Drug Discount Program by 33 percent. The payment for drugs
229.18 administered in an outpatient setting shall be made to the administering facility or
229.19 practitioner. A retail or specialty pharmacy dispensing a drug for administration in an
229.20 outpatient setting is not eligible for direct reimbursement.

229.21 (e) The commissioner may negotiate lower reimbursement rates for specialty
229.22 pharmacy products than the rates specified in paragraph (a). The commissioner may
229.23 require individuals enrolled in the health care programs administered by the department
229.24 to obtain specialty pharmacy products from providers with whom the commissioner has
229.25 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
229.26 used by a small number of recipients or recipients with complex and chronic diseases
229.27 that require expensive and challenging drug regimens. Examples of these conditions
229.28 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
229.29 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
229.30 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
229.31 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
229.32 that require complex care. The commissioner shall consult with the formulary committee
229.33 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
229.34 with the formulary committee in developing this list, the commissioner shall take into
229.35 consideration the population served by specialty pharmacy products, the current delivery

230.1 system and standard of care in the state, and access to care issues. The commissioner shall
230.2 have the discretion to adjust the reimbursement rate to prevent access to care issues.
230.3 (f) Home infusion therapy services provided by home infusion therapy pharmacies
230.4 must be paid at rates according to subdivision 8d.

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

230.6 Sec. 3. Minnesota Statutes 2012, section 256B.0625, subdivision 31, is amended to read:
230.7 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
230.8 supplies and equipment. Separate payment outside of the facility's payment rate shall
230.9 be made for wheelchairs and wheelchair accessories for recipients who are residents
230.10 of intermediate care facilities for the developmentally disabled. Reimbursement for
230.11 wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same
230.12 conditions and limitations as coverage for recipients who do not reside in institutions. A
230.13 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
230.14 The commissioner may set reimbursement rates for specified categories of medical
230.15 supplies at levels below the Medicare payment rate.
230.16 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
230.17 must enroll as a Medicare provider.
230.18 (c) When necessary to ensure access to durable medical equipment, prosthetics,
230.19 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare
230.20 enrollment requirement if:
230.21 (1) the vendor supplies only one type of durable medical equipment, prosthetic,
230.22 orthotic, or medical supply;
230.23 (2) the vendor serves ten or fewer medical assistance recipients per year;
230.24 (3) the commissioner finds that other vendors are not available to provide same or
230.25 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and
230.26 (4) the vendor complies with all screening requirements in this chapter and Code of
230.27 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
230.28 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
230.29 and Medicaid Services approved national accreditation organization as complying with
230.30 the Medicare program's supplier and quality standards and the vendor serves primarily
230.31 pediatric patients.
230.32 (d) Durable medical equipment means a device or equipment that:
230.33 (1) can withstand repeated use;
230.34 (2) is generally not useful in the absence of an illness, injury, or disability; and

231.1 (3) is provided to correct or accommodate a physiological disorder or physical
231.2 condition or is generally used primarily for a medical purpose.
231.3 (e) Electronic tablets may be considered durable medical equipment if the electronic
231.4 tablet will be used as an augmentative and alternative communication system as defined
231.5 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device
231.6 must be locked in order to prevent use not related to communication.

231.7 Sec. 4. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
231.8 subdivision to read:
231.9 Subd. 31b. **Preferred diabetic testing supply program.** (a) The commissioner
231.10 shall adopt and implement a point of sale preferred diabetic testing supply program by
231.11 January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform
231.12 to the limitations established under the program. The commissioner may enter into a
231.13 contract with a vendor for the purpose of participating in a preferred diabetic testing
231.14 supply list and supplemental rebate program. The commissioner shall ensure that any
231.15 contract meets all federal requirements and maximizes federal financial participation. The
231.16 commissioner shall maintain an accurate and up-to-date list on the agency Web site.
231.17 (b) The commissioner may add to, delete from, and otherwise modify the preferred
231.18 diabetic testing supply program drug list after consulting with the Drug Formulary
231.19 Committee and appropriate medial specialists and providing public notice and the
231.20 opportunity for public comment.
231.21 (c) The commissioner shall adopt and administer the preferred diabetic testing
231.22 supply program as part of the administration of the diabetic testing supply rebate program.
231.23 Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply
231.24 list may be subject to prior authorization.
231.25 (d) All claims for diabetic testing supplies in categories on the preferred diabetic
231.26 testing supply list must be submitted by enrolled pharmacy providers using the most
231.27 current National Council of Prescription Drug Providers electronic claims standard.
231.28 (e) For purposes of this subdivision, "preferred diabetic testing supply list" means a
231.29 list of diabetic testing supplies selected by the commissioner, for which prior authorization
231.30 is not required.
231.31 (f) The commissioner shall seek any federal waivers or approvals necessary to
231.32 implement this subdivision.

231.33 Sec. 5. Minnesota Statutes 2012, section 256B.0625, subdivision 39, is amended to read:

232.1 Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines
232.2 within the scope of their licensure, and who are enrolled as a medical assistance provider,
232.3 must enroll in the pediatric vaccine administration program established by section 13631
232.4 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay ~~an~~
232.5 ~~$8.50 fee per dose~~ for administration of the vaccine to children eligible for medical
232.6 assistance. Medical assistance does not pay for vaccines that are available at no cost from
232.7 the pediatric vaccine administration program.

232.8 Sec. 6. Minnesota Statutes 2012, section 256B.0625, subdivision 58, is amended to read:
232.9 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**
232.10 Medical assistance covers early and periodic screening, diagnosis, and treatment services
232.11 (EPSDT). The payment amount for a complete EPSDT screening shall not include charges
232.12 for vaccines that are available at no cost to the provider and shall not exceed the rate
232.13 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

232.14 Sec. 7. Minnesota Statutes 2012, section 256B.76, is amended by adding a subdivision
232.15 to read:
232.16 Subd. 7. **Payment for certain primary care services and immunization**
232.17 **administration.** Payment for certain primary care services and immunization
232.18 administration services rendered on or after January 1, 2013, through December 31, 2014,
232.19 shall be made in accordance with section 1902(a)(13) of the Social Security Act.

232.20 Sec. 8. Minnesota Statutes 2012, section 256B.764, is amended to read:

232.21 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**
232.22 (a) Effective for services rendered on or after July 1, 2007, payment rates for family
232.23 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,
232.24 when these services are provided by a community clinic as defined in section 145.9268,
232.25 subdivision 1.
232.26 (b) Effective for services rendered on or after July 1, 2013, payment rates for
232.27 family planning services shall be increased by 20 percent over the rates in effect June
232.28 30, 2013, when these services are provided by a community clinic as defined in section
232.29 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care
232.30 and county-based purchasing plans to reflect this increase, and shall require plans to pass
232.31 on the full amount of the rate increase to eligible community clinics, in the form of higher
232.32 payment rates for family planning services.

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

233.2 ## ARTICLE 8

233.3 ## CONTINUING CARE

233.4 Section 1. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

233.5 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
233.6 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
233.7 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
233.8 9555.6265, under this chapter for a physical location that will not be the primary residence
233.9 of the license holder for the entire period of licensure. If a license is issued during this
233.10 moratorium, and the license holder changes the license holder's primary residence away
233.11 from the physical location of the foster care license, the commissioner shall revoke the
233.12 license according to section 245A.07. Exceptions to the moratorium include:

233.13 (1) foster care settings that are required to be registered under chapter 144D;

233.14 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
233.15 and determined to be needed by the commissioner under paragraph (b);

233.16 (3) new foster care licenses determined to be needed by the commissioner under
233.17 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or
233.18 restructuring of state-operated services that limits the capacity of state-operated facilities,
233.19 or, allowing movement to the community for people who no longer require the level of
233.20 care provided in state-operated facilities as provided under section 256B.092, subdivision
233.21 13, or 256B.49, subdivision 24;

233.22 (4) new foster care licenses determined to be needed by the commissioner under
233.23 paragraph (b) for persons requiring hospital level care; or

233.24 (5) new foster care licenses determined to be needed by the commissioner for the
233.25 transition of people from personal care assistance to the home and community-based
233.26 services.

233.27 (b) The commissioner shall determine the need for newly licensed foster care homes
233.28 as defined under this subdivision. As part of the determination, the commissioner shall
233.29 consider the availability of foster care capacity in the area in which the licensee seeks to
233.30 operate, and the recommendation of the local county board. The determination by the
233.31 commissioner must be final. A determination of need is not required for a change in
233.32 ownership at the same address.

233.33 ~~(c) The commissioner shall study the effects of the license moratorium under this~~
233.34 ~~subdivision and shall report back to the legislature by January 15, 2011. This study shall~~
233.35 ~~include, but is not limited to the following:~~

~~(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;~~

~~(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and~~

~~(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.~~

~~(d)~~ (c) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for foster care settings where the physical location is not the primary residence of the license holder, if the voluntary changes described in paragraph ~~(f)~~ (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county, and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

~~(e)~~ (d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph ~~(d)~~ (c) shall be exempt under the following circumstances:

(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:

(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;

(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or

235.1 (iv) a provider of intensive residential treatment services (IRTS) licensed under
235.2 Minnesota Rules, parts 9520.0500 to 9520.0670; or
235.3 (2) the license holder's beds occupied by residents whose primary diagnosis is
235.4 mental illness and the license holder is certified under the requirements in subdivision 6a.
235.5 (f) (e) A resource need determination process, managed at the state level, using the
235.6 available reports required by section 144A.351, and other data and information shall
235.7 be used to determine where the reduced capacity required under paragraph (d) (c) will
235.8 be implemented. The commissioner shall consult with the stakeholders described in
235.9 section 144A.351, and employ a variety of methods to improve the state's capacity to
235.10 meet long-term care service needs within budgetary limits, including seeking proposals
235.11 from service providers or lead agencies to change service type, capacity, or location to
235.12 improve services, increase the independence of residents, and better meet needs identified
235.13 by the long-term care services reports and statewide data and information. By February
235.14 1 of each 2013 and August 1 of 2014 and each following year, the commissioner shall
235.15 provide information and data on the overall capacity of licensed long-term care services,
235.16 actions taken under this subdivision to manage statewide long-term care services and
235.17 supports resources, and any recommendations for change to the legislative committees
235.18 with jurisdiction over health and human services budget.
235.19 (g) (f) At the time of application and reapplication for licensure, the applicant and the
235.20 license holder that are subject to the moratorium or an exclusion established in paragraph
235.21 (a) are required to inform the commissioner whether the physical location where the foster
235.22 care will be provided is or will be the primary residence of the license holder for the entire
235.23 period of licensure. If the primary residence of the applicant or license holder changes, the
235.24 applicant or license holder must notify the commissioner immediately. The commissioner
235.25 shall print on the foster care license certificate whether or not the physical location is the
235.26 primary residence of the license holder.
235.27 (h) (g) License holders of foster care homes identified under paragraph (g) (f) that
235.28 are not the primary residence of the license holder and that also provide services in the
235.29 foster care home that are covered by a federally approved home and community-based
235.30 services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must
235.31 inform the human services licensing division that the license holder provides or intends to
235.32 provide these waiver-funded services. These license holders must be considered registered
235.33 under section 256B.092, subdivision 11, paragraph (c), and this registration status must
235.34 be identified on their license certificates.

236.1 Sec. 2. [256.478] HOME AND COMMUNITY-BASED SERVICES
236.2 **TRANSITIONS GRANTS.**
236.3 (a) The commissioner shall make available home and community-based services
236.4 transition grants to serve individuals who do not meet eligibility criteria for the medical
236.5 assistance program under section 256B.056 or 256B.057, but who otherwise meet the
236.6 criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.
236.7 (b) For the purposes of this section, the commissioner has the authority to transfer
236.8 funds between the medical assistance account and the home and community-based
236.9 services transitions grants account.

236.10 Sec. 3. Minnesota Statutes 2012, section 256B.0911, subdivision 4d, is amended to read:
236.11 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a)
236.12 It is the policy of the state of Minnesota to ensure that individuals with disabilities or
236.13 chronic illness are served in the most integrated setting appropriate to their needs and have
236.14 the necessary information to make informed choices about home and community-based
236.15 service options.
236.16 (b) Individuals under 65 years of age who are admitted to a nursing facility from a
236.17 hospital must be screened prior to admission as outlined in subdivisions 4a through 4c.
236.18 (c) Individuals under 65 years of age who are admitted to nursing facilities with
236.19 only a telephone screening must receive a face-to-face assessment from the long-term
236.20 care consultation team member of the county in which the facility is located or from the
236.21 recipient's county case manager within 40 calendar days of admission.
236.22 (d) Individuals under 65 years of age who are admitted to a nursing facility
236.23 without preadmission screening according to the exemption described in subdivision 4b,
236.24 paragraph (a), clause (3), and who remain in the facility longer than 30 days must receive
236.25 a face-to-face assessment within 40 days of admission.
236.26 (e) At the face-to-face assessment, the long-term care consultation team member or
236.27 county case manager must perform the activities required under subdivision 3b.
236.28 (f) For individuals under 21 years of age, a screening interview which recommends
236.29 nursing facility admission must be face-to-face and approved by the commissioner before
236.30 the individual is admitted to the nursing facility.
236.31 (g) In the event that an individual under 65 years of age is admitted to a nursing
236.32 facility on an emergency basis, the county must be notified of the admission on the
236.33 next working day, and a face-to-face assessment as described in paragraph (c) must be
236.34 conducted within 40 calendar days of admission.

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

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

237.14 (j) Notwithstanding the provisions of subdivision 6, the commissioner may pay
237.15 county agencies directly for face-to-face assessments for individuals under 65 years of age
237.16 who are being considered for placement or residing in a nursing facility. Until September
237.17 30, 2013, payments for individuals under 65 years of age shall be made as described
237.18 in this subdivision.

237.19 Sec. 4. Minnesota Statutes 2012, section 256B.0911, subdivision 6, is amended to read:

237.20 Subd. 6. **Payment for long-term care consultation services.** (a) Until September
237.21 30, 2013, payment for long-term care consultation face-to-face assessment shall be made
237.22 as described in this subdivision.

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

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

237.33 ~~(c)~~ (d) In the event of the layaway, delicensure and decertification, or removal from
237.34 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the
237.35 per diem payment amount in paragraph ~~(b)~~ (c) and may adjust the monthly payment

238.1 amount in paragraph (a). The effective date of an adjustment made under this paragraph
238.2 shall be on or after the first day of the month following the effective date of the layaway,
238.3 delicensure and decertification, or removal from layaway.

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

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

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

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

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

238.31 Sec. 5. Minnesota Statutes 2012, section 256B.0916, is amended by adding a
238.32 subdivision to read:

238.33 Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending
238.34 in excess of the allocation made by the commissioner. In the event a county or tribal
238.35 agency spends in excess of the allocation made by the commissioner for a given allocation

239.1 period, they must submit a corrective action plan to the commissioner. The plan must state
239.2 the actions the agency will take to correct their overspending for the year following the
239.3 period when the overspending occurred. Failure to correct overspending shall result in
239.4 recoupment of spending in excess of the allocation. Nothing in this subdivision shall be
239.5 construed as reducing the county's responsibility to offer and make available feasible
239.6 home and community-based options to eligible waiver recipients within the resources
239.7 allocated to them for that purpose.

239.8 Sec. 6. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:
239.9 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
239.10 established a new service called residential support that is available on the community
239.11 alternative care, community alternatives for disabled individuals, developmental
239.12 disabilities, and brain injury waivers. Existing waiver service descriptions must be
239.13 modified to the extent necessary to ensure there is no duplication between other services.
239.14 Residential support services must be provided by vendors licensed as a community
239.15 residential setting as defined in section 245A.11, subdivision 8.
239.16 (b) Residential support services must meet the following criteria:
239.17 (1) providers of residential support services must own or control the residential site;
239.18 (2) the residential site must not be the primary residence of the license holder;
239.19 (3) the residential site must have a designated program supervisor responsible for
239.20 program oversight, development, and implementation of policies and procedures;
239.21 (4) the provider of residential support services must provide supervision, training,
239.22 and assistance as described in the person's coordinated service and support plan; and
239.23 (5) the provider of residential support services must meet the requirements of
239.24 licensure and additional requirements of the person's coordinated service and support plan.
239.25 (c) Providers of residential support services that meet the definition in paragraph
239.26 (a) must be registered using a process determined by the commissioner beginning July
239.27 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts
239.28 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts
239.29 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision
239.30 7, paragraph ~~(g)~~ (f), are considered registered under this section.

239.31 Sec. 7. Minnesota Statutes 2012, section 256B.092, subdivision 12, is amended to read:
239.32 Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall
239.33 establish statewide priorities for individuals on the waiting list for developmental
239.34 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must

240.1 include, but are not limited to, individuals who continue to have a need for waiver services
240.2 after they have maximized the use of state plan services and other funding resources,
240.3 including natural supports, prior to accessing waiver services, and who meet at least one
240.4 of the following criteria:
240.5 (1) no longer require the intensity of services provided where they are currently
240.6 living; or
240.7 (2) make a request to move from an institutional setting.
240.8 (b) After the priorities in paragraph (a) are met, priority must also be given to
240.9 individuals who meet at least one of the following criteria:
240.10 (1) have unstable living situations due to the age, incapacity, or sudden loss of
240.11 the primary caregivers;
240.12 (2) are moving from an institution due to bed closures;
240.13 (3) experience a sudden closure of their current living arrangement;
240.14 (4) require protection from confirmed abuse, neglect, or exploitation;
240.15 (5) experience a sudden change in need that can no longer be met through state plan
240.16 services or other funding resources alone; or
240.17 (6) meet other priorities established by the department.
240.18 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
240.19 consideration the number of individuals waiting who meet statewide priorities and the
240.20 lead agencies' current use of waiver funds and existing service options. The commissioner
240.21 has the authority to transfer funds between counties, groups of counties, and tribes to
240.22 accommodate statewide priorities and resource needs while accounting for a necessary
240.23 base level reserve amount for each county, group of counties, and tribe.
240.24 ~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and~~
240.25 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
240.26 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
240.27 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

240.28 Sec. 8. Minnesota Statutes 2012, section 256B.092, is amended by adding a
240.29 subdivision to read:
240.30 Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner
240.31 shall make available additional waiver allocations and additional necessary resources
240.32 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
240.33 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:
240.34 (1) are otherwise eligible for the developmental disabilities waiver under this section;

241.1 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
241.2 the Minnesota Security Hospital;
241.3 (3) whose discharge would be significantly delayed without the available waiver
241.4 allocation; and
241.5 (4) who have met treatment objectives and no longer meet hospital level of care.
241.6 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
241.7 requirements of the federal approved waiver plan.
241.8 (c) Any corporate foster care home developed under this subdivision must be
241.9 considered an exception under section 245A.03, subdivision 7, paragraph (a).

241.10 Sec. 9. **[256B.0949] AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.**
241.11 Subdivision 1. **Purpose.** This section creates a new benefit available under the
241.12 medical assistance state plan 1915(i) option to provide early intensive intervention to a
241.13 child with an autism spectrum disorder diagnosis. This benefit must provide coverage for
241.14 the comprehensive, multidisciplinary diagnostic assessment, ongoing progress evaluation,
241.15 and medically necessary treatment of autism spectrum disorder. This option must be
241.16 available upon federal approval, but not earlier than March 1, 2014.
241.17 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in
241.18 this subdivision have the meanings given.
241.19 (b) "Autism spectrum disorder diagnosis" is defined by diagnostic code 299 in the
241.20 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
241.21 (c) "Child" means a person under the age of 18.
241.22 (d) "Early intensive intervention benefit" means autism treatment options based in
241.23 behavioral and developmental science, which may include modalities such as applied
241.24 behavioral analysis, developmental treatment approaches, and naturalistic and parent
241.25 training models.
241.26 (e) "Commissioner" means the commissioner of human services, unless otherwise
241.27 specified.
241.28 (f) "Generalizable" means goals or gains that are observed in a variety of activities
241.29 with different people, such as providers, family members, other adults, and children and
241.30 in different environments including, but not limited to, clinics, homes, schools, and the
241.31 community.
241.32 Subd. 3. **Initial eligibility.** (a) This benefit is available to a child receiving medical
241.33 assistance who has an autism spectrum disorder diagnosis and who meets the criteria for
241.34 medically necessary early intensive intervention services.

242.1 (b) A comprehensive diagnosis must be based upon current DSM criteria including
242.2 direct observations and parental or caregiver reports. The comprehensive diagnosis
242.3 must reflect both medical and mental health input as provided by a licensed health care
242.4 professional and a licensed mental health professional.
242.5 (c) Additional diagnostic assessments may be provided as needed by professionals
242.6 who are licensed experts in the fields of medicine, speech and language, psychology,
242.7 occupational therapy, and physical therapy.
242.8 (d) Special education assessments may also be considered in the diagnostic
242.9 assessment.
242.10 (e) The multidisciplinary diagnostic assessment must lead to an individualized
242.11 treatment plan.
242.12 Subd. 4. **Treatment plan.** (a) Each child's treatment plan must be family centered,
242.13 culturally sensitive, and individualized based on the child's needs and developmental
242.14 status. The treatment plan must specify developmentally appropriate, functional,
242.15 generalizable goals, treatment modality, intensity, and setting. Treatment must be overseen
242.16 by a licensed health care or mental health professional with expertise and training in
242.17 autism and child development.
242.18 (b) A functional assessment must identify the child's developmental skills, needs,
242.19 and capacities based on direct observation of the child. It may include, but is not limited
242.20 to, input provided by the child's special education teacher.
242.21 (c) An assessment of parental or caregiver resilience and ability to participate in
242.22 therapy must be conducted to determine the nature and level of parental or caregiver
242.23 involvement and training.
242.24 (d) The treatment plan must be submitted to the commissioner for approval in a
242.25 manner determined by the commissioner for this purpose.
242.26 (e) The commissioner must authorize services consistent with approved treatment
242.27 plans.
242.28 Subd. 5. **Ongoing eligibility.** A child receiving this benefit must receive an
242.29 independent progress evaluation by a licensed mental health professional every six
242.30 months, or more frequently as determined by the commissioner, to determine if progress is
242.31 being made toward achieving generalizable gains and meeting functional goals contained
242.32 in the treatment plan. The progress evaluation must determine if the treatment plan
242.33 needs modification. This progress evaluation must include the treating provider's report,
242.34 parental or caregiver input, and an independent observation of the child. For children
242.35 participating in special education, the observation component of this progress evaluation
242.36 may be performed by the child's special education teacher. Progress evaluations must be

243.1 submitted to the commissioner in a manner determined by the commissioner for this
243.2 purpose. A child who continues to achieve generalizable gains and treatment goals as
243.3 contained in the treatment plan is eligible to continue receiving this benefit.

243.4 Subd. 6. **Refining the benefit with stakeholders.** The commissioner must develop
243.5 the implementation details of the benefit in consultation with stakeholders and consider
243.6 recommendations from the Health Services Advisory Council, the Autism Spectrum
243.7 Disorder Advisory Council, and the Interagency Task Force of the Departments of Health,
243.8 Education, and Human Services. The commissioner must release these details for a 30-day
243.9 public comment period prior to submission to the federal government for approval. The
243.10 implementation details include, but are not limited to, the following:

243.11 (1) defining the qualifications, standards, and roles of the treatment team;

243.12 (2) developing initial, uniform parameters for multidisciplinary diagnostic
243.13 assessment and progress evaluation standards;

243.14 (3) developing an effective and consistent process for assessing parent and caregiver
243.15 resilience and capacity to participate in the child's early intervention treatment;

243.16 (4) forming a collaborative process in which professionals have opportunities to
243.17 collectively inform diagnostic assessment and progress evaluation processes and standards
243.18 and to support quality improvement of early intensive intervention services;

243.19 (5) coordination with and interaction of this benefit with other services provided by
243.20 the Departments of Human Services and Education; and

243.21 (6) ongoing evaluation of and research regarding the program and treatment
243.22 modalities provided to children under this benefit.

243.23 Subd. 7. **Revision of treatment options.** The commissioner may revise covered
243.24 treatment options as needed to ensure consistency with evolving evidence.

243.25 Subd. 8. **Coordination between agencies.** The commissioners of human services
243.26 and education must coordinate diagnostic and educational assessment, service delivery,
243.27 and progress evaluations across health and education sectors.

243.28 Sec. 10. Minnesota Statutes 2012, section 256B.434, subdivision 4, is amended to read:

243.29 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
243.30 have their payment rates determined under this section rather than section 256B.431, the
243.31 commissioner shall establish a rate under this subdivision. The nursing facility must enter
243.32 into a written contract with the commissioner.

243.33 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
243.34 contract under this section is the payment rate the facility would have received under
243.35 section 256B.431.

244.1 (c) A nursing facility's case mix payment rates for the second and subsequent years
244.2 of a facility's contract under this section are the previous rate year's contract payment
244.3 rates plus an inflation adjustment and, for facilities reimbursed under this section or
244.4 section 256B.431, an adjustment to include the cost of any increase in Health Department
244.5 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
244.6 inflation adjustment must be based on the change in the Consumer Price Index-All Items
244.7 (United States City average) (CPI-U) forecasted by the commissioner of management and
244.8 budget's national economic consultant, as forecasted in the fourth quarter of the calendar
244.9 year preceding the rate year. The inflation adjustment must be based on the 12-month
244.10 period from the midpoint of the previous rate year to the midpoint of the rate year for
244.11 which the rate is being determined. For the rate years beginning on July 1, 1999, July 1,
244.12 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006,
244.13 July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall
244.14 apply only to the property-related payment rate. For the rate years beginning on October
244.15 1, 2011, ~~and~~ October 1, 2012, <u>October 1, 2013, October 1, 2014, October 1, 2015, and</u>
244.16 <u>October 1, 2016,</u> the rate adjustment under this paragraph shall be suspended. Beginning
244.17 in 2005, adjustment to the property payment rate under this section and section 256B.431
244.18 shall be effective on October 1. In determining the amount of the property-related payment
244.19 rate adjustment under this paragraph, the commissioner shall determine the proportion of
244.20 the facility's rates that are property-related based on the facility's most recent cost report.
244.21 (d) The commissioner shall develop additional incentive-based payments of up to
244.22 five percent above a facility's operating payment rate for achieving outcomes specified
244.23 in a contract. The commissioner may solicit contract amendments and implement those
244.24 which, on a competitive basis, best meet the state's policy objectives. The commissioner
244.25 shall limit the amount of any incentive payment and the number of contract amendments
244.26 under this paragraph to operate the incentive payments within funds appropriated for this
244.27 purpose. The contract amendments may specify various levels of payment for various
244.28 levels of performance. Incentive payments to facilities under this paragraph may be in the
244.29 form of time-limited rate adjustments or onetime supplemental payments. In establishing
244.30 the specified outcomes and related criteria, the commissioner shall consider the following
244.31 state policy objectives:
244.32 (1) successful diversion or discharge of residents to the residents' prior home or other
244.33 community-based alternatives;
244.34 (2) adoption of new technology to improve quality or efficiency;
244.35 (3) improved quality as measured in the Nursing Home Report Card;
244.36 (4) reduced acute care costs; and

245.1 (5) any additional outcomes proposed by a nursing facility that the commissioner
245.2 finds desirable.

245.3 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
245.4 take action to come into compliance with existing or pending requirements of the life
245.5 safety code provisions or federal regulations governing sprinkler systems must receive
245.6 reimbursement for the costs associated with compliance if all of the following conditions
245.7 are met:

245.8 (1) the expenses associated with compliance occurred on or after January 1, 2005,
245.9 and before December 31, 2008;

245.10 (2) the costs were not otherwise reimbursed under subdivision 4f or section
245.11 144A.071 or 144A.073; and

245.12 (3) the total allowable costs reported under this paragraph are less than the minimum
245.13 threshold established under section 256B.431, subdivision 15, paragraph (e), and
245.14 subdivision 16.

245.15 The commissioner shall use money appropriated for this purpose to provide to qualifying
245.16 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
245.17 2008. Nursing facilities that have spent money or anticipate the need to spend money
245.18 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
245.19 system or (2) replacing all or portions of an existing sprinkler system may submit to the
245.20 commissioner by June 30, 2007, on a form provided by the commissioner the actual
245.21 costs of a completed project or the estimated costs, based on a project bid, of a planned
245.22 project. The commissioner shall calculate a rate adjustment equal to the allowable
245.23 costs of the project divided by the resident days reported for the report year ending
245.24 September 30, 2006. If the costs from all projects exceed the appropriation for this
245.25 purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the
245.26 qualifying facilities by reducing the rate adjustment determined for each facility by an
245.27 equal percentage. Facilities that used estimated costs when requesting the rate adjustment
245.28 shall report to the commissioner by January 31, 2009, on the use of this money on a
245.29 form provided by the commissioner. If the nursing facility fails to provide the report, the
245.30 commissioner shall recoup the money paid to the facility for this purpose. If the facility
245.31 reports expenditures allowable under this subdivision that are less than the amount received
245.32 in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

245.33 Sec. 11. Minnesota Statutes 2012, section 256B.437, subdivision 6, is amended to read:

Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's ~~total operating~~ external fixed payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an ~~operating payment~~ external fixed rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(e) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

(f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment shall be effective from the date the per bed dollar amount is increased.

(g) For planned closures approved after June 30, 2009, the commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

(h) ~~Beginning~~ Between July 16, 2011, and June 30, 2013, the commissioner shall ~~no longer~~ not accept applications for planned closure rate adjustments under subdivision 3.

247.1 Sec. 12. **[256B.4391] HOME AND COMMUNITY-BASED SERVICES QUALITY**
247.2 **PROFILES.**

247.3 Subdivision 1. **Development and implementation of quality profiles.** (a) The
247.4 commissioner of human services, in cooperation with the commissioner of health, shall
247.5 develop and implement quality profiles for home and community-based services (HCBS)
247.6 providers, except when the quality profiles would duplicate requirements under section
247.7 256B.5011, 256B.5012, or 256B.5013. For purposes of this section, HCBS providers
247.8 are defined as providers of HCBS under sections 256B.0915, 256B.092, and 256B.49,
247.9 and ICF/DD providers under section 256B.5013. To the extent possible, quality profiles
247.10 must be developed for providers of services to older adults and people with disabilities,
247.11 regardless of payor source, for the purposes of providing information to consumers.
247.12 The quality profiles shall be developed using existing data sets maintained by the
247.13 commissioners of health and human services to the extent possible. The profiles shall
247.14 incorporate or be coordinated with information on quality maintained by area agencies
247.15 on aging, long-term service and supports provider trade associations, the ombudsman
247.16 offices, counties, tribes, health plans, and other entities and the long-term services and
247.17 supports database maintained under section 256.975, subdivision 7. The profiles must be
247.18 designed to provide information on quality to:

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

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

247.22 (3) public and private purchasers of HCBS to enable them to purchase high-quality
247.23 services.

247.24 (b) The profiles must be developed in consultation with stakeholders and experts.
247.25 Within the limits of available appropriations, the commissioner may employ consultants
247.26 to assist with this project.

247.27 Subd. 2. **Quality measurement tools.** (a) The commissioners shall identify and
247.28 apply quality measurement tools to:

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

247.30 (2) address the needs of various users of HCBS.

247.31 (b) The tools must include, but not be limited to, surveys of consumers of HCBS. The
247.32 tools must be identified and applied, to the extent possible, without requiring providers to
247.33 supply information beyond state and federal requirements, for purposes of this subdivision.

247.34 Subd. 3. **Consumer surveys.** Following identification of the quality measurement
247.35 tool, the commissioner shall conduct surveys of HCBS consumers to develop quality
247.36 profiles of providers. To the extent possible, surveys must be conducted face-to-face by

248.1 state employees or contractors. At the discretion of the commissioner, surveys may be
248.2 conducted by an alternative method. Surveys must be conducted periodically to update
248.3 quality profiles of individual service providers.

248.4 Subd. 4. **Home and community-based services report card.** The profiles
248.5 developed shall be incorporated into a report card and maintained by the Minnesota
248.6 Board of Aging under section 256.975, subdivision 7, paragraph (b), clause (2), as data
248.7 becomes available. The commissioner shall use consumer choice, quality of life, service
248.8 delivery approaches, and cost or flexible purchasing categories to organize the consumer
248.9 information in the profiles. The profiles shall include consumer input and survey data to
248.10 the extent that is available through the state agencies. The commissioner shall develop and
248.11 disseminate quality profiles for a limited number of provider types initially, and develop
248.12 quality profiles for additional provider types as measurement tools are developed and
248.13 data becomes available. This includes providers of services to older adults and people
248.14 with disabilities, regardless of payor source.

248.15 Subd. 5. **Dissemination of quality profiles.** By July 1, 2014, the commissioner
248.16 shall implement a public awareness effort to disseminate the quality profiles. Profiles
248.17 may be disseminated through the Senior LinkAge Line and Disability Linkage Line to
248.18 consumers, providers, and purchasers of HCBS.

248.19 Subd. 6. **Implementation of home and community-based services**
248.20 **performance-based incentive payment program.** By July 1, 2014, the commissioner
248.21 shall develop incentive-based grants for HCBS providers for achieving outcomes specified
248.22 in a contract. The commissioner may solicit proposals from HCBS providers and
248.23 implement those which, on a competitive basis, best meet the state's policy objectives.
248.24 The commissioner shall determine the types of HCBS providers that will participate in the
248.25 program. The determination of participating provider types may be revised annually by
248.26 the commissioner. The commissioner shall limit the amount of any incentive-based grants
248.27 and the number of grants under this subdivision to operate the incentive payments within
248.28 funds appropriated for this purpose. The grant agreements may specify various levels of
248.29 payment for various levels of performance. In establishing the specified outcomes and
248.30 related criteria, the commissioner shall consider the following state policy objectives:

248.31 (1) provide more efficient, higher quality services;

248.32 (2) encourage HCBS providers to innovate;

248.33 (3) equip HCBS providers with organizational tools and expertise to improve their
248.34 quality;

248.35 (4) incentivize HCBS providers to invest in better services; and

248.36 (5) disseminate successful performance improvement strategies statewide.

249.1 Subd. 7. **Calculation of HCBS quality score.** (a) The commissioner shall
249.2 determine a quality score for each participating HCBS provider using quality measures
249.3 established in subdivisions 1 and 2, according to methods determined by the commissioner
249.4 in consultation with stakeholders and experts. These methods shall be exempt from the
249.5 rulemaking requirements under chapter 14.
249.6 (b) For each quality measure, a score shall be determined with a maximum number
249.7 of points available and number of points assigned as determined by the commissioner
249.8 using the methodology established according to this subdivision. The determination of
249.9 the quality measures to be used and the methods of calculating scores may be revised
249.10 annually be the commissioner.
249.11 Subd. 8. **Calculation of HCBS quality add-on.** Effective January 1, 2016, the
249.12 commissioner shall determine the quality add-on payment for participating HCBS
249.13 providers. The payment rate for the quality add-on shall be a variable amount based on
249.14 each provider's quality score as determined in subdivisions 1 and 2. The commissioner
249.15 shall limit the types of HCBS providers that may receive the quality add-on and the
249.16 amount of the quality add-on payments to operate the quality add-on within funds
249.17 appropriated for this purpose and based on the availability of the quality measures.

249.18 Sec. 13. Minnesota Statutes 2012, section 256B.441, subdivision 13, is amended to read:
249.19 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the
249.20 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
249.21 section 144.122; until September 30, 2013, long-term care consultation fees under
249.22 section 256B.0911, subdivision 6; family advisory council fee under section 144A.33;
249.23 scholarships under section 256B.431, subdivision 36; planned closure rate adjustments
249.24 under section 256B.437; or single bed room incentives under section 256B.431,
249.25 subdivision 42; property taxes and property insurance; and PERA.

249.26 Sec. 14. Minnesota Statutes 2012, section 256B.441, is amended by adding a
249.27 subdivision to read:
249.28 Subd. 46b. **Calculation of operating rate increase and quality add-on for the**
249.29 **October 1, 2013, rate year.** (a) Effective October 1, 2013, the commissioner shall
249.30 implement operating payment rate increases for each facility. The increase shall be equal
249.31 to 1.09 percent multiplied by the difference between the operating rates in effect on
249.32 September 30, 2013, less any amount received under section 256B.434, subdivision 4.
249.33 (b) The commissioner shall determine quality add-ons to the operating payment rates
249.34 for each facility. The quality add-on amounts shall be based on rates in effect on September

250.1 30, 2013, less any amount received under section 256B.434, subdivision 4. For each
250.2 facility, the commissioner shall compute a quality factor by subtracting 40 from the most
250.3 recent quality score computed under subdivision 44, and then dividing by 60. If the quality
250.4 factor is less than zero, the commissioner shall use the value zero. The quality add-ons
250.5 shall be the operating payment rates multiplied by the quality factor multiplied by 2.60
250.6 percent. The commissioner shall implement the quality add-ons effective October 1, 2013.
250.7 (c) Facilities receiving rate adjustments under subdivision 55a must have rate
250.8 increases under paragraphs (a) and (b) computed based on their rates in effect before the
250.9 increases given under subdivision 55a became effective. The amount of rate increases
250.10 computed under this subdivision shall be added to the rates that the nursing facility would
250.11 otherwise be paid without application of subdivision 55a.

250.12 Sec. 15. Minnesota Statutes 2012, section 256B.441, is amended by adding a
250.13 subdivision to read:
250.14 Subd. 46c. **Calculation of operating rate increase and quality add-on for the**
250.15 **October 1, 2014, rate year.** (a) Effective October 1, 2014, the commissioner shall
250.16 implement operating payment rate increases for each facility. The increase shall be equal
250.17 to 1.09 percent multiplied by the difference between the operating rates in effect on
250.18 September 30, 2014, less any amount received under section 256B.434, subdivision 4.
250.19 (b) The commissioner shall determine quality add-ons to the operating payment rates
250.20 for each facility. The quality add-on amounts shall be based on rates in effect on September
250.21 30, 2014, less any amount received under section 256B.434, subdivision 4. For each
250.22 facility, the commissioner shall compute a quality factor by subtracting 40 from the most
250.23 recent quality score computed under subdivision 44, and then dividing by 60. If the quality
250.24 factor is less than zero, the commissioner shall use the value zero. The quality add-ons
250.25 shall be the operating payment rates multiplied by the quality factor multiplied by 2.60
250.26 percent. The commissioner shall implement the quality add-ons effective October 1, 2014.
250.27 (c) Facilities receiving rate adjustments under subdivision 55a must have rate
250.28 increases under paragraphs (a) and (b) computed based on their rates before subdivision
250.29 55a became effective. The amount of rate increases computed under this subdivision shall
250.30 be added to the rates that the nursing facility would otherwise be paid without application
250.31 of subdivision 55a, but after the increases computed in subdivision 46b.

250.32 Sec. 16. Minnesota Statutes 2012, section 256B.441, is amended by adding a
250.33 subdivision to read:

251.1 Subd. 46d. **Calculation of quality add-on for the October 1, 2015, rate year.** (a)
251.2 The commissioner shall determine quality add-ons to the operating payment rates for each
251.3 facility. The quality add-on amounts shall be based on rates in effect on September 30,
251.4 2015, less any amount received under section 256B.434, subdivision 4. For each facility,
251.5 the commissioner shall compute a quality factor by subtracting 40 from the most recent
251.6 quality score computed under subdivision 44, and then dividing by 60. If the quality factor
251.7 is less than zero, the commissioner shall use the value zero. The quality add-ons shall be
251.8 the operating payment rates multiplied by the quality factor multiplied by 5.40 percent.
251.9 The commissioner shall implement the quality add-ons effective October 1, 2015.
251.10 (b) Facilities receiving rate adjustments under subdivision 55a must have rate
251.11 increases under paragraph (a) computed based on their rates before subdivision 55a
251.12 became effective. The amount of rate increases computed under this subdivision shall be
251.13 added to the rates that the nursing facility would otherwise be paid without application of
251.14 subdivision 55a, but after the sum of the increases computed in subdivisions 46b and 46c.

251.15 Sec. 17. Minnesota Statutes 2012, section 256B.441, is amended by adding a
251.16 subdivision to read:
251.17 Subd. 46e. **Calculation of quality add-on for the October 1, 2016, rate year.** (a)
251.18 The commissioner shall determine quality add-ons to the operating payment rates for each
251.19 facility. The quality add-on amounts shall be based on rates in effect on September 30,
251.20 2016, less any amount received under section 256B.434, subdivision 4. For each facility,
251.21 the commissioner shall compute a quality factor by subtracting 40 from the most recent
251.22 quality score computed under subdivision 44, and then dividing by 60. If the quality factor
251.23 is less than zero, the commissioner shall use the value zero. The quality add-ons shall be
251.24 the operating payment rates multiplied by the quality factor multiplied by 5.40 percent.
251.25 The commissioner shall implement the quality add-ons effective October 1, 2016.
251.26 (b) Facilities receiving rate adjustments under subdivision 55a must have rate
251.27 increases under paragraph (a) computed based on their rates before subdivision 55a
251.28 became effective. The amount of rate increases computed under this subdivision shall be
251.29 added to the rates that the nursing facility would otherwise be paid without application of
251.30 subdivision 55a, but after the sum of the increases computed in subdivisions 46b to 46d.

251.31 Sec. 18. Minnesota Statutes 2012, section 256B.441, subdivision 53, is amended to read:
251.32 Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner
251.33 shall calculate a payment rate for external fixed costs.

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

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

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

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

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

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

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

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

252.25 (i) The single bed room incentives shall be as determined under section 256B.431,
252.26 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
252.27 no longer be included in the payment rate for external fixed costs beginning October 1,
252.28 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no
252.29 longer be included in the payment rate for external fixed costs beginning on October 1 of
252.30 the first year not less than two years after their effective date.

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

252.33 Sec. 19. Minnesota Statutes 2012, section 256B.49, subdivision 11a, is amended to read:

252.34 Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall
252.35 establish statewide priorities for individuals on the waiting list for community alternative

253.1 care, community alternatives for disabled individuals, and brain injury waiver services,
253.2 as of January 1, 2010. The statewide priorities must include, but are not limited to,
253.3 individuals who continue to have a need for waiver services after they have maximized the
253.4 use of state plan services and other funding resources, including natural supports, prior to
253.5 accessing waiver services, and who meet at least one of the following criteria:
253.6 (1) no longer require the intensity of services provided where they are currently
253.7 living; or
253.8 (2) make a request to move from an institutional setting.
253.9 (b) After the priorities in paragraph (a) are met, priority must also be given to
253.10 individuals who meet at least one of the following criteria:
253.11 (1) have unstable living situations due to the age, incapacity, or sudden loss of
253.12 the primary caregivers;
253.13 (2) are moving from an institution due to bed closures;
253.14 (3) experience a sudden closure of their current living arrangement;
253.15 (4) require protection from confirmed abuse, neglect, or exploitation;
253.16 (5) experience a sudden change in need that can no longer be met through state plan
253.17 services or other funding resources alone; or
253.18 (6) meet other priorities established by the department.
253.19 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
253.20 consideration the number of individuals waiting who meet statewide priorities and the
253.21 lead agencies' current use of waiver funds and existing service options. The commissioner
253.22 has the authority to transfer funds between counties, groups of counties, and tribes to
253.23 accommodate statewide priorities and resource needs while accounting for a necessary
253.24 base level reserve amount for each county, group of counties, and tribe.
253.25 ~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and~~
253.26 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
253.27 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
253.28 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

253.29 Sec. 20. Minnesota Statutes 2012, section 256B.49, subdivision 15, is amended to read:
253.30 Subd. 15. **Coordinated service and support plan; comprehensive transitional**
253.31 **service plan; maintenance service plan.** (a) Each recipient of home and community-based
253.32 waivered services shall be provided a copy of the written coordinated service and support
253.33 plan which meets the requirements in section 256B.092, subdivision 1b.
253.34 (b) In developing the comprehensive transitional service plan, the individual
253.35 receiving services, the case manager, and the guardian, if applicable, will identify the

254.1 transitional service plan fundamental service outcome and anticipated timeline to achieve
254.2 this outcome. Within the first 20 days following a recipient's request for an assessment or
254.3 reassessment, the transitional service planning team must be identified. A team leader must
254.4 be identified who will be responsible for assigning responsibility and communicating with
254.5 team members to ensure implementation of the transition plan and ongoing assessment and
254.6 communication process. The team leader should be an individual, such as the case manager
254.7 or guardian, who has the opportunity to follow the recipient to the next level of service.

254.8 Within ten days following an assessment, a comprehensive transitional service plan
254.9 must be developed incorporating elements of a comprehensive functional assessment and
254.10 including short-term measurable outcomes and timelines for achievement of and reporting
254.11 on these outcomes. Functional milestones must also be identified and reported according
254.12 to the timelines agreed upon by the transitional service planning team. In addition, the
254.13 comprehensive transitional service plan must identify additional supports that may assist
254.14 in the achievement of the fundamental service outcome such as the development of greater
254.15 natural community support, increased collaboration among agencies, and technological
254.16 supports.

254.17 The timelines for reporting on functional milestones will prompt a reassessment of
254.18 services provided, the units of services, rates, and appropriate service providers. It is
254.19 the responsibility of the transitional service planning team leader to review functional
254.20 milestone reporting to determine if the milestones are consistent with observable skills
254.21 and that milestone achievement prompts any needed changes to the comprehensive
254.22 transitional service plan.

254.23 For those whose fundamental transitional service outcome involves the need to
254.24 procure housing, a plan for the recipient to seek the resources necessary to secure the least
254.25 restrictive housing possible should be incorporated into the plan, including employment
254.26 and public supports such as housing access and shelter needy funding.

254.27 (c) Counties and other agencies responsible for funding community placement and
254.28 ongoing community supportive services are responsible for the implementation of the
254.29 comprehensive transitional service plans. Oversight responsibilities include both ensuring
254.30 effective transitional service delivery and efficient utilization of funding resources.

254.31 (d) Following one year of transitional services, the transitional services planning team
254.32 will make a determination as to whether or not the individual receiving services requires
254.33 the current level of continuous and consistent support in order to maintain the recipient's
254.34 current level of functioning. Recipients who are determined to have not had a significant
254.35 change in functioning for 12 months must move from a transitional to a maintenance
254.36 service plan. Recipients on a maintenance service plan must be reassessed to determine if

255.1 the recipient would benefit from a transitional service plan at least every 12 months and at
255.2 other times when there has been a significant change in the recipient's functioning. This
255.3 assessment should consider any changes to technological or natural community supports.

255.4 (e) When a county is evaluating denials, reductions, or terminations of home and
255.5 community-based services under section 256B.49 for an individual, the case manager
255.6 shall offer to meet with the individual or the individual's guardian in order to discuss
255.7 the prioritization of service needs within the coordinated service and support plan,
255.8 comprehensive transitional service plan, or maintenance service plan. The reduction in
255.9 the authorized services for an individual due to changes in funding for waivered services
255.10 may not exceed the amount needed to ensure medically necessary services to meet the
255.11 individual's health, safety, and welfare.

255.12 (f) At the time of reassessment, local agency case managers shall assess each recipient
255.13 of community alternatives for disabled individuals or brain injury waivered services
255.14 currently residing in a licensed adult foster home that is not the primary residence of the
255.15 license holder, or in which the license holder is not the primary caregiver, to determine if
255.16 that recipient could appropriately be served in a community-living setting. If appropriate
255.17 for the recipient, the case manager shall offer the recipient, through a person-centered
255.18 planning process, the option to receive alternative housing and service options. In the
255.19 event that the recipient chooses to transfer from the adult foster home, the vacated bed
255.20 shall not be filled with another recipient of waiver services and group residential housing
255.21 and the licensed capacity shall be reduced accordingly, unless the savings required by the
255.22 licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7,
255.23 sections 1 and 40, paragraph (f), for foster care settings where the physical location is not
255.24 the primary residence of the license holder are met through voluntary changes described
255.25 in section 245A.03, subdivision 7, paragraph ~~(f)~~ (e), or as provided under paragraph (a),
255.26 clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers,
255.27 the county agency, with the assistance of the department, shall facilitate a consolidation of
255.28 settings or closure. This reassessment process shall be completed by July 1, 2013.

255.29 Sec. 21. Minnesota Statutes 2012, section 256B.49, is amended by adding a
255.30 subdivision to read:

255.31 Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner
255.32 shall make available additional waiver allocations and additional necessary resources
255.33 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
255.34 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

256.1 (1) are otherwise eligible for the brain injury, community alternatives for disabled
256.2 individuals, or community alternative care waivers under this section;
256.3 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
256.4 the Minnesota Security Hospital;
256.5 (3) whose discharge would be significantly delayed without the available waiver
256.6 allocation; and
256.7 (4) who have met treatment objectives and no longer meet hospital level of care.
256.8 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
256.9 requirements of the federal approved waiver plan.
256.10 (c) Any corporate foster care home developed under this subdivision must be
256.11 considered an exception under section 245A.03, subdivision 7, paragraph (a).

256.12 Sec. 22. Minnesota Statutes 2012, section 256B.49, is amended by adding a
256.13 subdivision to read:
256.14 Subd. 25. **Excess allocations.** County and tribal agencies will be responsible for
256.15 authorizations in excess of the allocation made by the commissioner. In the event a county
256.16 or tribal agency authorizes in excess of the allocation made by the commissioner for a
256.17 given allocation period, they must submit a corrective action plan to the commissioner.
256.18 The plan must state the actions the agency will take to correct their over-authorization
256.19 for the year following the period when the overspending occurred. Failure to correct
256.20 over-authorizations shall result in recoupment of authorizations in excess of the allocation.
256.21 Nothing in this subdivision shall be construed as reducing the county's responsibility to
256.22 offer and make available feasible home and community-based options to eligible waiver
256.23 recipients within the resources allocated to them for that purpose.

256.24 Sec. 23. Minnesota Statutes 2012, section 256B.493, subdivision 2, is amended to read:
256.25 Subd. 2. **Planned closure process needs determination.** The commissioner shall
256.26 announce and implement a program for planned closure of adult foster care homes. Planned
256.27 closure shall be the preferred method for achieving necessary budgetary savings required by
256.28 the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph ~~(d)~~
256.29 (c). If additional closures are required to achieve the necessary savings, the commissioner
256.30 shall use the process and priorities in section 245A.03, subdivision 7, paragraph ~~(d)~~ (c).

256.31 Sec. 24. **SAFETY NET FOR HOME AND COMMUNITY-BASED SERVICES**
256.32 **WAIVERS.**

257.1 The commissioner of human services shall submit a request by December 31, 2013,
257.2 to the federal government to amend the home and community-based services waivers for
257.3 individuals with disabilities authorized under Minnesota Statutes, section 256B.49, to
257.4 modify the financial management of the home and community-based services waivers
257.5 to provide a state-administered safety net when costs for an individual increase above
257.6 an identified threshold. The implementation of the safety net may result in a decreased
257.7 allocation for individual counties, tribes, or collaboratives of counties or tribes, but must
257.8 not result in a net decreased statewide allocation.

257.9 Sec. 25. **SHARED LIVING MODEL.**

257.10 The commissioner of human services shall develop and promote a shared living model
257.11 option for individuals receiving services through the home and community-based services
257.12 waivers for individuals with disabilities, authorized under Minnesota Statutes, section
257.13 256B.092 or 256B.49, as an option for individuals who require 24-hour assistance. The
257.14 option must be a companion model with a limit of one or two individuals receiving support
257.15 in the home, planned respite for the caregiver, and the availability of intensive training
257.16 and support on the needs of the individual or individuals. Any necessary amendments to
257.17 implement the model must be submitted to the federal government by December 31, 2013.

257.18 Sec. 26. **MONEY FOLLOWS THE PERSON GRANT.**

257.19 The commissioner of human services shall submit to the federal government all
257.20 necessary waiver amendments to implement the Money Follows the Person federal grant
257.21 by December 31, 2013.

257.22 Sec. 27. **REPEALER.**

257.23 Minnesota Statutes 2012, section 256B.5012, subdivision 13, and Laws 2011, First
257.24 Special Session chapter 9, article 7, section 54, as amended by Laws 2012, chapter 247,
257.25 article 4, section 42, and Laws 2012, chapter 298, section 3, are repealed.

257.26 **ARTICLE 9**

257.27 **WAIVER PROVIDER STANDARDS**

257.28 Section 1. Minnesota Statutes 2012, section 145C.01, subdivision 7, is amended to read:
257.29 Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity
257.30 licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under
257.31 section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47,
257.32 an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts

9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or a hospice provider licensed under sections 144A.75 to 144A.755.

Sec. 2. Minnesota Statutes 2012, section 243.166, subdivision 4b, is amended to read:

Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this subdivision, "health care facility" means a facility:

(1) licensed by the commissioner of health as a hospital, boarding care home or supervised living facility under sections 144.50 to 144.58, or a nursing home under chapter 144A;

(2) registered by the commissioner of health as a housing with services establishment as defined in section 144D.01; or

(3) licensed by the commissioner of human services as a residential facility under chapter 245A to provide adult foster care, adult mental health treatment, chemical dependency treatment to adults, or residential services to persons with ~~developmental~~ disabilities.

(b) Prior to admission to a health care facility, a person required to register under this section shall disclose to:

(1) the health care facility employee processing the admission the person's status as a registered predatory offender under this section; and

(2) the person's corrections agent, or if the person does not have an assigned corrections agent, the law enforcement authority with whom the person is currently required to register, that inpatient admission will occur.

(c) A law enforcement authority or corrections agent who receives notice under paragraph (b) or who knows that a person required to register under this section is planning to be admitted and receive, or has been admitted and is receiving health care at a health care facility shall notify the administrator of the facility and deliver a fact sheet to the administrator containing the following information: (1) name and physical description of the offender; (2) the offender's conviction history, including the dates of conviction; (3) the risk level classification assigned to the offender under section 244.052, if any; and (4) the profile of likely victims.

(d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care facility receives a fact sheet under paragraph (c) that includes a risk level classification for the offender, and if the facility admits the offender, the facility shall distribute the fact sheet to all residents at the facility. If the facility determines that distribution to a resident is not appropriate given the resident's medical, emotional, or mental status, the facility shall distribute the fact sheet to the patient's next of kin or emergency contact.

259.1 Sec. 3. **[245.8251] POSITIVE SUPPORT STRATEGIES AND EMERGENCY**
259.2 **MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.**
259.3 Subdivision 1. **Rules.** The commissioner of human services shall, within 24 months
259.4 of enactment of this section, adopt rules governing the use of positive support strategies,
259.5 safety interventions, and emergency use of manual restraint in facilities and services
259.6 licensed under chapter 245D.
259.7 Subd. 2. **Data collection.** (a) The commissioner shall, with stakeholder input,
259.8 develop data collection elements specific to incidents on the use of controlled procedures
259.9 with persons receiving services from providers regulated under Minnesota Rules, parts
259.10 9525.2700 to 9525.2810, and incidents involving persons receiving services from
259.11 providers identified to be licensed under chapter 245D effective January 1, 2014. Providers
259.12 shall report the data in a format and at a frequency provided by the commissioner of
259.13 human services.
259.14 (b) Beginning July 1, 2013, providers regulated under Minnesota Rules, parts
259.15 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures
259.16 in a format and at a frequency provided by the commissioner.

259.17 Sec. 4. Minnesota Statutes 2012, section 245A.02, subdivision 10, is amended to read:
259.18 Subd. 10. **Nonresidential program.** "Nonresidential program" means care,
259.19 supervision, rehabilitation, training or habilitation of a person provided outside the
259.20 person's own home and provided for fewer than 24 hours a day, including adult day
259.21 care programs; and chemical dependency or chemical abuse programs that are located
259.22 in a nursing home or hospital and receive public funds for providing chemical abuse or
259.23 chemical dependency treatment services under chapter 254B. Nonresidential programs
259.24 include home and community-based services ~~and semi-independent living services~~ for
259.25 persons with ~~developmental~~ disabilities or persons age 65 and older that are provided in
259.26 or outside of a person's own home under chapter 245D.

259.27 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 14, is amended to read:
259.28 Subd. 14. **Residential program.** "Residential program" means a program
259.29 that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training,
259.30 education, habilitation, or treatment outside a person's own home, including a program
259.31 in an intermediate care facility for four or more persons with developmental disabilities;
259.32 and chemical dependency or chemical abuse programs that are located in a hospital
259.33 or nursing home and receive public funds for providing chemical abuse or chemical
259.34 dependency treatment services under chapter 254B. Residential programs include home

260.1 and community-based services for persons with ~~developmental~~ disabilities or persons age
260.2 65 and older that are provided in or outside of a person's own home under chapter 245D.

260.3 Sec. 6. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:
260.4 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial
260.5 license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340,
260.6 or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under
260.7 this chapter for a physical location that will not be the primary residence of the license
260.8 holder for the entire period of licensure. If a license is issued during this moratorium, and
260.9 the license holder changes the license holder's primary residence away from the physical
260.10 location of the foster care license, the commissioner shall revoke the license according
260.11 to section 245A.07. The commissioner shall not issue an initial license for a community
260.12 residential setting licensed under chapter 245D. Exceptions to the moratorium include:
260.13 (1) foster care settings that are required to be registered under chapter 144D;
260.14 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
260.15 community residential setting licenses replacing adult foster care licenses in existence on
260.16 December 31, 2013, and determined to be needed by the commissioner under paragraph (b);
260.17 (3) new foster care licenses or community residential setting licenses determined to
260.18 be needed by the commissioner under paragraph (b) for the closure of a nursing facility,
260.19 ICF/MR, or regional treatment center, or restructuring of state-operated services that
260.20 limits the capacity of state-operated facilities;
260.21 (4) new foster care licenses or community residential setting licenses determined
260.22 to be needed by the commissioner under paragraph (b) for persons requiring hospital
260.23 level care; or
260.24 (5) new foster care licenses or community residential setting licenses determined to
260.25 be needed by the commissioner for the transition of people from personal care assistance
260.26 to the home and community-based services.
260.27 (b) The commissioner shall determine the need for newly licensed foster care
260.28 homes or community residential settings as defined under this subdivision. As part of the
260.29 determination, the commissioner shall consider the availability of foster care capacity in
260.30 the area in which the licensee seeks to operate, and the recommendation of the local
260.31 county board. The determination by the commissioner must be final. A determination of
260.32 need is not required for a change in ownership at the same address.
260.33 (c) The commissioner shall study the effects of the license moratorium under this
260.34 subdivision and shall report back to the legislature by January 15, 2011. This study shall
260.35 include, but is not limited to the following:

261.1 (1) the overall capacity and utilization of foster care beds where the physical location
261.2 is not the primary residence of the license holder prior to and after implementation
261.3 of the moratorium;
261.4 (2) the overall capacity and utilization of foster care beds where the physical
261.5 location is the primary residence of the license holder prior to and after implementation
261.6 of the moratorium; and
261.7 (3) the number of licensed and occupied ICF/MR beds prior to and after
261.8 implementation of the moratorium.
261.9 (d) When a ~~foster care recipient~~ resident served by the program moves out of a
261.10 foster home that is not the primary residence of the license holder according to section
261.11 256B.49, subdivision 15, paragraph (f), or the community residential setting, the county
261.12 shall immediately inform the Department of Human Services Licensing Division.
261.13 The department shall decrease the statewide licensed capacity for foster care settings
261.14 where the physical location is not the primary residence of the license holder, or for
261.15 community residential settings, if the voluntary changes described in paragraph (f) are
261.16 not sufficient to meet the savings required by reductions in licensed bed capacity under
261.17 Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f),
261.18 and maintain statewide long-term care residential services capacity within budgetary
261.19 limits. Implementation of the statewide licensed capacity reduction shall begin on July
261.20 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the
261.21 needs determination process. Under this paragraph, the commissioner has the authority
261.22 to reduce unused licensed capacity of a current foster care program, or the community
261.23 residential settings, to accomplish the consolidation or closure of settings. A decreased
261.24 licensed capacity according to this paragraph is not subject to appeal under this chapter.
261.25 (e) Residential settings that would otherwise be subject to the decreased license
261.26 capacity established in paragraph (d) shall be exempt under the following circumstances:
261.27 (1) until August 1, 2013, the license holder's beds occupied by residents whose
261.28 primary diagnosis is mental illness and the license holder is:
261.29 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
261.30 health services (ARMHS) as defined in section 256B.0623;
261.31 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
261.32 9520.0870;
261.33 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
261.34 9520.0870; or
261.35 (iv) a provider of intensive residential treatment services (IRTS) licensed under
261.36 Minnesota Rules, parts 9520.0500 to 9520.0670; or

262.1 (2) the license holder is certified under the requirements in subdivision 6a or section
262.2 245D.33.

262.3 (f) A resource need determination process, managed at the state level, using the
262.4 available reports required by section 144A.351, and other data and information shall
262.5 be used to determine where the reduced capacity required under paragraph (d) will be
262.6 implemented. The commissioner shall consult with the stakeholders described in section
262.7 144A.351, and employ a variety of methods to improve the state's capacity to meet
262.8 long-term care service needs within budgetary limits, including seeking proposals from
262.9 service providers or lead agencies to change service type, capacity, or location to improve
262.10 services, increase the independence of residents, and better meet needs identified by the
262.11 long-term care services reports and statewide data and information. By February 1 of each
262.12 year, the commissioner shall provide information and data on the overall capacity of
262.13 licensed long-term care services, actions taken under this subdivision to manage statewide
262.14 long-term care services and supports resources, and any recommendations for change to
262.15 the legislative committees with jurisdiction over health and human services budget.

262.16 (g) At the time of application and reapplication for licensure, the applicant and the
262.17 license holder that are subject to the moratorium or an exclusion established in paragraph
262.18 (a) are required to inform the commissioner whether the physical location where the foster
262.19 care will be provided is or will be the primary residence of the license holder for the entire
262.20 period of licensure. If the primary residence of the applicant or license holder changes, the
262.21 applicant or license holder must notify the commissioner immediately. The commissioner
262.22 shall print on the foster care license certificate whether or not the physical location is the
262.23 primary residence of the license holder.

262.24 (h) License holders of foster care homes identified under paragraph (g) that are not
262.25 the primary residence of the license holder and that also provide services in the foster care
262.26 home that are covered by a federally approved home and community-based services
262.27 waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the
262.28 human services licensing division that the license holder provides or intends to provide
262.29 these waiver-funded services. ~~These license holders must be considered registered under~~
262.30 ~~section 256B.092, subdivision 11, paragraph (c), and this registration status must be~~
262.31 ~~identified on their license certificates.~~

262.32 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 8, is amended to read:

262.33 Subd. 8. **Excluded providers seeking licensure.** Nothing in this section shall
262.34 prohibit a program that is excluded from licensure under subdivision 2, paragraph
262.35 (a), clause ~~(28)~~ (26), from seeking licensure. The commissioner shall ensure that any

263.1 application received from such an excluded provider is processed in the same manner as
263.2 all other applications for child care center licensure.

263.3 Sec. 8. Minnesota Statutes 2012, section 245A.042, subdivision 3, is amended to read:
263.4 Subd. 3. **Implementation.** (a) The commissioner shall implement the
263.5 responsibilities of this chapter according to the timelines in paragraphs (b) and (c)
263.6 only within the limits of available appropriations or other administrative cost recovery
263.7 methodology.
263.8 (b) The licensure of home and community-based services according to this section
263.9 shall be implemented January 1, 2014. License applications shall be received and
263.10 processed on a phased-in schedule as determined by the commissioner beginning July
263.11 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that
263.12 the application is complete according to section 245A.04.
263.13 (c) Within the limits of available appropriations or other administrative cost recovery
263.14 methodology, implementation of compliance monitoring must be phased in after January
263.15 1, 2014.
263.16 (1) Applicants who do not currently hold a license issued under ~~this~~ chapter 245B
263.17 must receive an initial compliance monitoring visit after 12 months of the effective date of
263.18 the initial license for the purpose of providing technical assistance on how to achieve and
263.19 maintain compliance with the applicable law or rules governing the provision of home and
263.20 community-based services under chapter 245D. If during the review the commissioner
263.21 finds that the license holder has failed to achieve compliance with an applicable law or
263.22 rule and this failure does not imminently endanger the health, safety, or rights of the
263.23 persons served by the program, the commissioner may issue a licensing review report with
263.24 recommendations for achieving and maintaining compliance.
263.25 (2) Applicants who do currently hold a license issued under this chapter must receive
263.26 a compliance monitoring visit after 24 months of the effective date of the initial license.
263.27 (d) Nothing in this subdivision shall be construed to limit the commissioner's
263.28 authority to suspend or revoke a license or issue a fine at any time under section 245A.07,
263.29 or ~~make~~ issue correction orders and make a license conditional for failure to comply with
263.30 applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity
263.31 of the violation of law or rule and the effect of the violation on the health, safety, or
263.32 rights of persons served by the program.

263.33 Sec. 9. Minnesota Statutes 2012, section 245A.08, subdivision 2a, is amended to read:

Subd. 2a. **Consolidated contested case hearings.** (a) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is based on a disqualification for which reconsideration was requested and which was not set aside under section 245C.22, the scope of the contested case hearing shall include the disqualification and the licensing sanction or denial of a license, unless otherwise specified in this subdivision. When the licensing sanction or denial of a license is based on a determination of maltreatment under section 626.556 or 626.557, or a disqualification for serious or recurring maltreatment which was not set aside, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and the licensing sanction or denial of a license, unless otherwise specified in this subdivision. In such cases, a fair hearing under section 256.045 shall not be conducted as provided for in sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

(b) Except for family child care and child foster care, reconsideration of a maltreatment determination under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of a disqualification under section 245C.22, shall not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder is based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction. In these cases, a fair hearing shall not be conducted under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d. The scope of the contested case hearing must include the maltreatment determination, disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

(c) In consolidated contested case hearings regarding sanctions issued in family child care, child foster care, family adult day services, ~~and~~ adult foster care<u>, and community</u>

265.1 residential settings, the county attorney shall defend the commissioner's orders in
265.2 accordance with section 245A.16, subdivision 4.

265.3 (d) The commissioner's final order under subdivision 5 is the final agency action
265.4 on the issue of maltreatment and disqualification, including for purposes of subsequent
265.5 background studies under chapter 245C and is the only administrative appeal of the final
265.6 agency determination, specifically, including a challenge to the accuracy and completeness
265.7 of data under section 13.04.

265.8 (e) When consolidated hearings under this subdivision involve a licensing sanction
265.9 based on a previous maltreatment determination for which the commissioner has issued
265.10 a final order in an appeal of that determination under section 256.045, or the individual
265.11 failed to exercise the right to appeal the previous maltreatment determination under
265.12 section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is
265.13 conclusive on the issue of maltreatment. In such cases, the scope of the administrative
265.14 law judge's review shall be limited to the disqualification and the licensing sanction or
265.15 denial of a license. In the case of a denial of a license or a licensing sanction issued to
265.16 a facility based on a maltreatment determination regarding an individual who is not the
265.17 license holder or a household member, the scope of the administrative law judge's review
265.18 includes the maltreatment determination.

265.19 (f) The hearings of all parties may be consolidated into a single contested case
265.20 hearing upon consent of all parties and the administrative law judge, if:

265.21 (1) a maltreatment determination or disqualification, which was not set aside under
265.22 section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing
265.23 sanction under section 245A.07;

265.24 (2) the disqualified subject is an individual other than the license holder and upon
265.25 whom a background study must be conducted under section 245C.03; and

265.26 (3) the individual has a hearing right under section 245C.27.

265.27 (g) When a denial of a license under section 245A.05 or a licensing sanction under
265.28 section 245A.07 is based on a disqualification for which reconsideration was requested
265.29 and was not set aside under section 245C.22, and the individual otherwise has no hearing
265.30 right under section 245C.27, the scope of the administrative law judge's review shall
265.31 include the denial or sanction and a determination whether the disqualification should
265.32 be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In
265.33 determining whether the disqualification should be set aside, the administrative law judge
265.34 shall consider the factors under section 245C.22, subdivision 4, to determine whether the
265.35 individual poses a risk of harm to any person receiving services from the license holder.

266.1 (h) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction
266.2 under section 245A.07 is based on the termination of a variance under section 245C.30,
266.3 subdivision 4, the scope of the administrative law judge's review shall include the sanction
266.4 and a determination whether the disqualification should be set aside, unless section
266.5 245C.24 prohibits the set-aside of the disqualification. In determining whether the
266.6 disqualification should be set aside, the administrative law judge shall consider the factors
266.7 under section 245C.22, subdivision 4, to determine whether the individual poses a risk of
266.8 harm to any person receiving services from the license holder.

266.9 Sec. 10. Minnesota Statutes 2012, section 245A.10, is amended to read:

266.10 **245A.10 FEES.**

266.11 Subdivision 1. **Application or license fee required, programs exempt from fee.**
266.12 (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation
266.13 of applications and inspection of programs which are licensed under this chapter.
266.14 (b) Except as provided under subdivision 2, no application or license fee shall be
266.15 charged for child foster care, adult foster care, ~~or~~ family and group family child care, or
266.16 a community residential setting.
266.17 Subd. 2. **County fees for background studies and licensing inspections.** (a) For
266.18 purposes of family and group family child care licensing under this chapter, a county
266.19 agency may charge a fee to an applicant or license holder to recover the actual cost of
266.20 background studies, but in any case not to exceed $100 annually. A county agency may
266.21 also charge a license fee to an applicant or license holder not to exceed $50 for a one-year
266.22 license or $100 for a two-year license.
266.23 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
266.24 applicant for authorization to recover the actual cost of background studies completed
266.25 under section 119B.125, but in any case not to exceed $100 annually.
266.26 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):
266.27 (1) in cases of financial hardship;
266.28 (2) if the county has a shortage of providers in the county's area;
266.29 (3) for new providers; or
266.30 (4) for providers who have attained at least 16 hours of training before seeking
266.31 initial licensure.
266.32 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
266.33 an installment basis for up to one year. If the provider is receiving child care assistance
266.34 payments from the state, the provider may have the fees under paragraph (a) or (b)

267.1 deducted from the child care assistance payments for up to one year and the state shall
267.2 reimburse the county for the county fees collected in this manner.
267.3 (e) For purposes of adult foster care and child foster care licensing, and licensing
267.4 the physical plant of a community residential setting, under this chapter, a county agency
267.5 may charge a fee to a corporate applicant or corporate license holder to recover the actual
267.6 cost of licensing inspections, not to exceed $500 annually.
267.7 (f) Counties may elect to reduce or waive the fees in paragraph (e) under the
267.8 following circumstances:
267.9 (1) in cases of financial hardship;
267.10 (2) if the county has a shortage of providers in the county's area; or
267.11 (3) for new providers.
267.12 Subd. 3. **Application fee for initial license or certification.** (a) For fees required
267.13 under subdivision 1, an applicant for an initial license or certification issued by the
267.14 commissioner shall submit a $500 application fee with each new application required
267.15 under this subdivision. An applicant for an initial day services facility license under
267.16 chapter 245D shall submit a $250 application fee with each new application. The
267.17 application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license
267.18 or certification fee that expires on December 31. The commissioner shall not process an
267.19 application until the application fee is paid.
267.20 (b) Except as provided in clauses (1) to ~~(4)~~ (3), an applicant shall apply for a license
267.21 to provide services at a specific location.
267.22 (1) ~~For a license to provide residential-based habilitation services to persons with~~
267.23 ~~developmental disabilities under chapter 245B, an applicant shall submit an application~~
267.24 ~~for each county in which the services will be provided. Upon licensure, the license~~
267.25 ~~holder may provide services to persons in that county plus no more than three persons~~
267.26 ~~at any one time in each of up to ten additional counties. A license holder in one county~~
267.27 ~~may not provide services under the home and community-based waiver for persons with~~
267.28 ~~developmental disabilities to more than three people in a second county without holding~~
267.29 ~~a separate license for that second county. Applicants or licensees providing services~~
267.30 ~~under this clause to not more than three persons remain subject to the inspection fees~~
267.31 ~~established in section 245A.10, subdivision 2, for each location. The license issued by~~
267.32 ~~the commissioner must state the name of each additional county where services are being~~
267.33 ~~provided to persons with developmental disabilities. A license holder must notify the~~
267.34 ~~commissioner before making any changes that would alter the license information listed~~
267.35 ~~under section 245A.04, subdivision 7, paragraph (a), including any additional counties~~
267.36 ~~where persons with developmental disabilities are being served.~~ For a license to provide

home and community-based services to persons with disabilities or age 65 and older under chapter 245D, an applicant shall submit an application to provide services statewide.

(2) ~~For a license to provide supported employment, crisis respite, or semi-independent living services to persons with developmental disabilities under chapter 245B, an applicant shall submit a single application to provide services statewide.~~

~~(3)~~ For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.

~~(4)~~ (3) For a license for a private agency to provide foster care or adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application to provide services statewide.

(c) The initial application fee charged under this subdivision does not include the temporary license surcharge under section 16E.22.

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

~~(b) A day training and habilitation program serving persons with developmental disabilities or related conditions shall pay an annual nonrefundable license fee based on the following schedule:~~

~~Licensed Capacity~~	~~License Fee~~
~~1 to 24 persons~~	~~$800~~
~~25 to 49 persons~~	~~$1,000~~
~~50 to 74 persons~~	~~$1,200~~
~~75 to 99 persons~~	~~$1,400~~
~~100 to 124 persons~~	~~$1,600~~
~~125 to 149 persons~~	~~$1,800~~
~~150 or more persons~~	~~$2,000~~

~~Except as provided in paragraph (c), when a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community,~~

269.1 ~~the day training and habilitation program shall pay a license fee based on the licensed~~
269.2 ~~capacity of the largest facility and the other facility or facilities shall be charged a license~~
269.3 ~~fee based on a licensed capacity of a residential program serving one to 24 persons.~~
269.4 ~~(c) When a day training and habilitation program serving persons with developmental~~
269.5 ~~disabilities or related conditions seeks a single license allowed under section 245B.07,~~
269.6 ~~subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed~~
269.7 ~~capacity for each location.~~
269.8 ~~(d) A program licensed to provide supported employment services to persons~~
269.9 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
269.10 ~~license fee of $650.~~
269.11 ~~(e) A program licensed to provide crisis respite services to persons with~~
269.12 ~~developmental disabilities under chapter 245B shall pay an annual nonrefundable license~~
269.13 ~~fee of $700.~~
269.14 ~~(f) A program licensed to provide semi-independent living services to persons~~
269.15 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
269.16 ~~license fee of $700.~~
269.17 ~~(g) A program licensed to provide residential-based habilitation services under the~~
269.18 ~~home and community-based waiver for persons with developmental disabilities shall pay~~
269.19 ~~an annual license fee that includes a base rate of $690 plus $60 times the number of clients~~
269.20 ~~served on the first day of July of the current license year.~~
269.21 ~~(h) A residential program certified by the Department of Health as an intermediate~~
269.22 ~~care facility for persons with developmental disabilities (ICF/MR) and a noncertified~~
269.23 ~~residential program licensed to provide health or rehabilitative services for persons~~
269.24 ~~with developmental disabilities shall pay an annual nonrefundable license fee based on~~
269.25 ~~the following schedule:~~

	~~Licensed Capacity~~	~~License Fee~~
269.26		
269.27	~~1 to 24 persons~~	~~$535~~
269.28	~~25 to 49 persons~~	~~$735~~
269.29	~~50 or more persons~~	~~$935~~

269.30 (b) A program licensed to provide one or more of the home and community-based
269.31 services and supports identified under chapter 245D to persons with disabilities or age
269.32 65 and older, shall pay an annual nonrefundable license fee that includes a base rate of
269.33 $1,125, plus $92 times the number of persons served on the last day of June of the current
269.34 license year for programs serving ten or more persons. The fee is limited to a maximum of
269.35 200 persons, regardless of the actual number of persons served. Programs serving nine
269.36 or fewer persons pay only the base rate.

(c) A facility licensed under chapter 245D to provide day services shall pay an annual nonrefundable license fee of $100.

~~(i)~~ (d) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

~~(j)~~ (e) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

~~(k)~~ (f) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

~~(l)~~ (g) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

~~(m)~~ (h) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

~~(n)~~ (i) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

~~(o)~~ (j) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

~~(p)~~ (k) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

~~(q)~~ (l) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

~~(r)~~ (m) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Subd. 6. **License not issued until license or certification fee is paid.** The commissioner shall not issue a license or certification until the license or certification fee is paid. The commissioner shall send a bill for the license or certification fee to the billing address identified by the license holder. If the license holder does not submit the license or certification fee payment by the due date, the commissioner shall send the license holder a past due notice. If the license holder fails to pay the license or certification fee by the due date on the past due notice, the commissioner shall send a final notice to the license holder informing the license holder that the program license will expire on December 31

272.1 unless the license fee is paid before December 31. If a license expires, the program is no
272.2 longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2,
272.3 must not operate after the expiration date. After a license expires, if the former license
272.4 holder wishes to provide licensed services, the former license holder must submit a new
272.5 license application and application fee under subdivision 3.

272.6 Subd. 7. **Human services licensing fees to recover expenditures.** Notwithstanding
272.7 section 16A.1285, subdivision 2, related to activities for which the commissioner charges
272.8 a fee, the commissioner must plan to fully recover direct expenditures for licensing
272.9 activities under this chapter over a five-year period. The commissioner may have
272.10 anticipated expenditures in excess of anticipated revenues in a biennium by using surplus
272.11 revenues accumulated in previous bienniums.

272.12 Subd. 8. **Deposit of license fees.** A human services licensing account is created in
272.13 the state government special revenue fund. Fees collected under subdivisions 3 and 4 must
272.14 be deposited in the human services licensing account and are annually appropriated to the
272.15 commissioner for licensing activities authorized under this chapter.

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

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

272.18 Subd. 2a. **Adult foster care and community residential setting license capacity.**
272.19 (a) The commissioner shall issue adult foster care and community residential setting
272.20 licenses with a maximum licensed capacity of four beds, including nonstaff roomers and
272.21 boarders, except that the commissioner may issue a license with a capacity of five beds,
272.22 including roomers and boarders, according to paragraphs (b) to (f).

272.23 (b) ~~An adult foster care~~ The license holder may have a maximum license capacity
272.24 of five if all persons in care are age 55 or over and do not have a serious and persistent
272.25 mental illness or a developmental disability.

272.26 (c) The commissioner may grant variances to paragraph (b) to allow a ~~foster care~~
272.27 ~~provider~~ facility with a licensed capacity of five persons to admit an individual under the
272.28 age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of
272.29 the variance is recommended by the county in which the licensed ~~foster care provider~~
272.30 facility is located.

272.31 (d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth
272.32 bed for emergency crisis services for a person with serious and persistent mental illness
272.33 or a developmental disability, regardless of age, if the variance complies with section
272.34 245A.04, subdivision 9, and approval of the variance is recommended by the county in
272.35 which the licensed ~~foster care provider~~ facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of a fifth bed for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed ~~foster care provider~~ facility is ~~licensed~~ located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the ~~foster care home~~ facility; and

(4) individuals living in the ~~foster care home~~ facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice

274.1 to remain living in the home and that the resident's refusal to consent would not have
274.2 resulted in service termination; and

274.3 (4) the facility was licensed for adult foster care before March 1, 2011.

274.4 (g) The commissioner shall not issue a new adult foster care license under paragraph
274.5 (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care
274.6 license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five
274.7 adults if the license holder continues to comply with the requirements in paragraph (f).

274.8 Sec. 12. Minnesota Statutes 2012, section 245A.11, subdivision 7, is amended to read:

274.9 Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The
274.10 commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts
274.11 requiring a caregiver to be present in an adult foster care home during normal sleeping
274.12 hours to allow for alternative methods of overnight supervision. The commissioner may
274.13 grant the variance if the local county licensing agency recommends the variance and the
274.14 county recommendation includes documentation verifying that:

274.15 (1) the county has approved the license holder's plan for alternative methods of
274.16 providing overnight supervision and determined the plan protects the residents' health,
274.17 safety, and rights;

274.18 (2) the license holder has obtained written and signed informed consent from
274.19 each resident or each resident's legal representative documenting the resident's or legal
274.20 representative's agreement with the alternative method of overnight supervision; and

274.21 (3) the alternative method of providing overnight supervision, which may include
274.22 the use of technology, is specified for each resident in the resident's: (i) individualized
274.23 plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if
274.24 required; or (iii) individual resident placement agreement under Minnesota Rules, part
274.25 9555.5105, subpart 19, if required.

274.26 (b) To be eligible for a variance under paragraph (a), the adult foster care license
274.27 holder must not have had a conditional license issued under section 245A.06, or any
274.28 other licensing sanction issued under section 245A.07 during the prior 24 months based
274.29 on failure to provide adequate supervision, health care services, or resident safety in
274.30 the adult foster care home.

274.31 (c) A license holder requesting a variance under this subdivision to utilize
274.32 technology as a component of a plan for alternative overnight supervision may request
274.33 the commissioner's review in the absence of a county recommendation. Upon receipt of
274.34 such a request from a license holder, the commissioner shall review the variance request
274.35 with the county.

275.1 (d) A variance granted by the commissioner according to this subdivision before
275.2 January 1, 2014, to a license holder for an adult foster care home must transfer with the
275.3 license when the license converts to a community residential setting license under chapter
275.4 245D. The terms and conditions of the variance remain in effect as approved at the time
275.5 the variance was granted.

275.6 Sec. 13. Minnesota Statutes 2012, section 245A.11, subdivision 7a, is amended to read:
275.7 Subd. 7a. **Alternate overnight supervision technology; adult foster care ~~license~~**
275.8 **and community residential setting licenses.** (a) The commissioner may grant an
275.9 applicant or license holder an adult foster care or community residential setting license
275.10 for a residence that does not have a caregiver in the residence during normal sleeping
275.11 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section
275.12 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder
275.13 when an incident occurs that may jeopardize the health, safety, or rights of a foster
275.14 care recipient. The applicant or license holder must comply with all other requirements
275.15 under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under
275.16 chapter 245D, and the requirements under this subdivision. The license printed by the
275.17 commissioner must state in bold and large font:
275.18 (1) that the facility is under electronic monitoring; and
275.19 (2) the telephone number of the county's common entry point for making reports of
275.20 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.
275.21 (b) Applications for a license under this section must be submitted directly to
275.22 the Department of Human Services licensing division. The licensing division must
275.23 immediately notify the ~~host county and lead county contract agency and the host~~ county
275.24 licensing agency. The licensing division must collaborate with the county licensing
275.25 agency in the review of the application and the licensing of the program.
275.26 (c) Before a license is issued by the commissioner, and for the duration of the
275.27 license, the applicant or license holder must establish, maintain, and document the
275.28 implementation of written policies and procedures addressing the requirements in
275.29 paragraphs (d) through (f).
275.30 (d) The applicant or license holder must have policies and procedures that:
275.31 (1) establish characteristics of target populations that will be admitted into the home,
275.32 and characteristics of populations that will not be accepted into the home;
275.33 (2) explain the discharge process when a ~~foster care recipient~~ resident served by the
275.34 program requires overnight supervision or other services that cannot be provided by the
275.35 license holder due to the limited hours that the license holder is on site;

(3) describe the types of events to which the program will respond with a physical presence when those events occur in the home during time when staff are not on site, and how the license holder's response plan meets the requirements in paragraph (e), clause (1) or (2);

(4) establish a process for documenting a review of the implementation and effectiveness of the response protocol for the response required under paragraph (e), clause (1) or (2). The documentation must include:

(i) a description of the triggering incident;

(ii) the date and time of the triggering incident;

(iii) the time of the response or responses under paragraph (e), clause (1) or (2);

(iv) whether the response met the resident's needs;

(v) whether the existing policies and response protocols were followed; and

(vi) whether the existing policies and protocols are adequate or need modification.

When no physical presence response is completed for a three-month period, the license holder's written policies and procedures must require a physical presence response drill to be conducted for which the effectiveness of the response protocol under paragraph (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

(5) establish that emergency and nonemergency phone numbers are posted in a prominent location in a common area of the home where they can be easily observed by a person responding to an incident who is not otherwise affiliated with the home.

(e) The license holder must document and include in the license application which response alternative under clause (1) or (2) is in place for responding to situations that present a serious risk to the health, safety, or rights of ~~people receiving foster care services in the home~~ residents served by the program:

(1) response alternative (1) requires only the technology to provide an electronic notification or alert to the license holder that an event is underway that requires a response. Under this alternative, no more than ten minutes will pass before the license holder will be physically present on site to respond to the situation; or

(2) response alternative (2) requires the electronic notification and alert system under alternative (1), but more than ten minutes may pass before the license holder is present on site to respond to the situation. Under alternative (2), all of the following conditions are met:

(i) the license holder has a written description of the interactive technological applications that will assist the license holder in communicating with and assessing the needs related to the care, health, and safety of the foster care recipients. This interactive technology must permit the license holder to remotely assess the well being of the ~~foster care recipient~~ resident served by the program without requiring the initiation of the

foster care recipient. Requiring the foster care recipient to initiate a telephone call does not meet this requirement;

(ii) the license holder documents how the remote license holder is qualified and capable of meeting the needs of the foster care recipients and assessing foster care recipients' needs under item (i) during the absence of the license holder on site;

(iii) the license holder maintains written procedures to dispatch emergency response personnel to the site in the event of an identified emergency; and

(iv) each ~~foster care recipient's~~ resident's individualized plan of care, ~~individual service plan~~ coordinated service and support plan under ~~section~~ sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, if required, or individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time, which may be greater than ten minutes, for the license holder to be on site for that ~~foster care recipient~~ resident.

(f) Each ~~foster care recipient's~~ resident's placement agreement, individual service agreement, and plan must clearly state that the adult foster care or community residential setting license category is a program without the presence of a caregiver in the residence during normal sleeping hours; the protocols in place for responding to situations that present a serious risk to the health, safety, or rights of ~~foster care recipients~~ residents served by the program under paragraph (e), clause (1) or (2); and a signed informed consent from each ~~foster care recipient~~ resident served by the program or the person's legal representative documenting the person's or legal representative's agreement with placement in the program. If electronic monitoring technology is used in the home, the informed consent form must also explain the following:

(1) how any electronic monitoring is incorporated into the alternative supervision system;

(2) the backup system for any electronic monitoring in times of electrical outages or other equipment malfunctions;

(3) how the caregivers or direct support staff are trained on the use of the technology;

(4) the event types and license holder response times established under paragraph (e);

(5) how the license holder protects ~~the foster care recipient's~~ each resident's privacy related to electronic monitoring and related to any electronically recorded data generated by the monitoring system. A ~~foster care recipient~~ resident served by the program may not be removed from a program under this subdivision for failure to consent to electronic monitoring. The consent form must explain where and how the electronically recorded data is stored, with whom it will be shared, and how long it is retained; and

278.1 (6) the risks and benefits of the alternative overnight supervision system.

278.2 The written explanations under clauses (1) to (6) may be accomplished through
278.3 cross-references to other policies and procedures as long as they are explained to the
278.4 person giving consent, and the person giving consent is offered a copy.

278.5 (g) Nothing in this section requires the applicant or license holder to develop or
278.6 maintain separate or duplicative policies, procedures, documentation, consent forms, or
278.7 individual plans that may be required for other licensing standards, if the requirements of
278.8 this section are incorporated into those documents.

278.9 (h) The commissioner may grant variances to the requirements of this section
278.10 according to section 245A.04, subdivision 9.

278.11 (i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning
278.12 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
278.13 contractors affiliated with the license holder.

278.14 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to
278.15 remotely determine what action the license holder needs to take to protect the well-being
278.16 of the foster care recipient.

278.17 (k) The commissioner shall evaluate license applications using the requirements
278.18 in paragraphs (d) to (f). The commissioner shall provide detailed application forms,
278.19 including a checklist of criteria needed for approval.

278.20 (l) To be eligible for a license under paragraph (a), the adult foster care or community
278.21 residential setting license holder must not have had a conditional license issued under
278.22 section 245A.06 or any licensing sanction under section 245A.07 during the prior 24
278.23 months based on failure to provide adequate supervision, health care services, or resident
278.24 safety in the adult foster care home or community residential setting.

278.25 (m) The commissioner shall review an application for an alternative overnight
278.26 supervision license within 60 days of receipt of the application. When the commissioner
278.27 receives an application that is incomplete because the applicant failed to submit required
278.28 documents or that is substantially deficient because the documents submitted do not meet
278.29 licensing requirements, the commissioner shall provide the applicant written notice
278.30 that the application is incomplete or substantially deficient. In the written notice to the
278.31 applicant, the commissioner shall identify documents that are missing or deficient and
278.32 give the applicant 45 days to resubmit a second application that is substantially complete.
278.33 An applicant's failure to submit a substantially complete application after receiving
278.34 notice from the commissioner is a basis for license denial under section 245A.05. The
278.35 commissioner shall complete subsequent review within 30 days.

279.1 (n) Once the application is considered complete under paragraph (m), the
279.2 commissioner will approve or deny an application for an alternative overnight supervision
279.3 license within 60 days.
279.4 (o) For the purposes of this subdivision, "supervision" means:
279.5 (1) oversight by a caregiver or direct support staff as specified in the individual
279.6 resident's place agreement or coordinated service and support plan and awareness of the
279.7 resident's needs and activities; and
279.8 (2) the presence of a caregiver or direct support staff in a residence during normal
279.9 sleeping hours, unless a determination has been made and documented in the individual's
279.10 coordinated service and support plan that the individual does not require the presence of a
279.11 caregiver or direct support staff during normal sleeping hours.

279.12 Sec. 14. Minnesota Statutes 2012, section 245A.11, subdivision 7b, is amended to read:
279.13 Subd. 7b. **Adult foster care data privacy and security.** (a) An adult foster care
279.14 or community residential setting license holder who creates, collects, records, maintains,
279.15 stores, or discloses any individually identifiable recipient data, whether in an electronic
279.16 or any other format, must comply with the privacy and security provisions of applicable
279.17 privacy laws and regulations, including:
279.18 (1) the federal Health Insurance Portability and Accountability Act of 1996
279.19 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations,
279.20 title 45, part 160, and subparts A and E of part 164; and
279.21 (2) the Minnesota Government Data Practices Act as codified in chapter 13.
279.22 (b) For purposes of licensure, the license holder shall be monitored for compliance
279.23 with the following data privacy and security provisions:
279.24 (1) the license holder must control access to data on ~~foster care recipients~~ residents
279.25 served by the program according to the definitions of public and private data on individuals
279.26 under section 13.02; classification of the data on individuals as private under section
279.27 13.46, subdivision 2; and control over the collection, storage, use, access, protection,
279.28 and contracting related to data according to section 13.05, in which the license holder is
279.29 assigned the duties of a government entity;
279.30 (2) the license holder must provide each ~~foster care recipient~~ resident served by
279.31 the program with a notice that meets the requirements under section 13.04, in which
279.32 the license holder is assigned the duties of the government entity, and that meets the
279.33 requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall
279.34 describe the purpose for collection of the data, and to whom and why it may be disclosed

280.1 pursuant to law. The notice must inform the ~~recipient~~ individual that the license holder
280.2 uses electronic monitoring and, if applicable, that recording technology is used;
280.3 (3) the license holder must not install monitoring cameras in bathrooms;
280.4 (4) electronic monitoring cameras must not be concealed from the ~~foster care~~
280.5 ~~recipients~~ residents served by the program; and
280.6 (5) electronic video and audio recordings of ~~foster care recipients~~ residents served
280.7 by the program shall be stored by the license holder for five days unless: (i) a ~~foster care~~
280.8 ~~recipient~~ resident served by the program or legal representative requests that the recording
280.9 be held longer based on a specific report of alleged maltreatment; or (ii) the recording
280.10 captures an incident or event of alleged maltreatment under section 626.556 or 626.557 or
280.11 a crime under chapter 609. When requested by a ~~recipient~~ resident served by the program
280.12 or when a recording captures an incident or event of alleged maltreatment or a crime, the
280.13 license holder must maintain the recording in a secured area for no longer than 30 days
280.14 to give the investigating agency an opportunity to make a copy of the recording. The
280.15 investigating agency will maintain the electronic video or audio recordings as required in
280.16 section 626.557, subdivision 12b.
280.17 (c) The commissioner shall develop, and make available to license holders and
280.18 county licensing workers, a checklist of the data privacy provisions to be monitored
280.19 for purposes of licensure.

280.20 Sec. 15. Minnesota Statutes 2012, section 245A.11, subdivision 8, is amended to read:
280.21 Subd. 8. **Community residential setting license.** (a) The commissioner shall
280.22 establish provider standards for residential support services that integrate service standards
280.23 and the residential setting under one license. The commissioner shall propose statutory
280.24 language and an implementation plan for licensing requirements for residential support
280.25 services to the legislature by January 15, 2012, as a component of the quality outcome
280.26 standards recommendations required by Laws 2010, chapter 352, article 1, section 24.
280.27 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
280.28 for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105
280.29 to 9555.6265~~, or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340~~;
280.30 and meeting the provisions of ~~section 256B.092, subdivision 11, paragraph (b)~~ section
280.31 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

280.32 Sec. 16. Minnesota Statutes 2012, section 245A.16, subdivision 1, is amended to read:
280.33 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
280.34 private agencies that have been designated or licensed by the commissioner to perform

281.1 licensing functions and activities under section 245A.04 and background studies for family
281.2 child care under chapter 245C; to recommend denial of applicants under section 245A.05;
281.3 to issue correction orders, to issue variances, and recommend a conditional license under
281.4 section 245A.06, or to recommend suspending or revoking a license or issuing a fine under
281.5 section 245A.07, shall comply with rules and directives of the commissioner governing
281.6 those functions and with this section. The following variances are excluded from the
281.7 delegation of variance authority and may be issued only by the commissioner:

281.8 (1) dual licensure of family child care and child foster care, dual licensure of child
281.9 and adult foster care, and adult foster care and family child care;

281.10 (2) adult foster care maximum capacity;

281.11 (3) adult foster care minimum age requirement;

281.12 (4) child foster care maximum age requirement;

281.13 (5) variances regarding disqualified individuals except that county agencies may
281.14 issue variances under section 245C.30 regarding disqualified individuals when the county
281.15 is responsible for conducting a consolidated reconsideration according to sections 245C.25
281.16 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
281.17 and a disqualification based on serious or recurring maltreatment; ~~and~~

281.18 (6) the required presence of a caregiver in the adult foster care residence during
281.19 normal sleeping hours; and

281.20 (7) variances for community residential setting licenses under chapter 245D.

281.21 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency
281.22 must not grant a license holder a variance to exceed the maximum allowable family child
281.23 care license capacity of 14 children.

281.24 (b) County agencies must report information about disqualification reconsiderations
281.25 under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances
281.26 granted under paragraph (a), clause (5), to the commissioner at least monthly in a format
281.27 prescribed by the commissioner.

281.28 (c) For family day care programs, the commissioner may authorize licensing reviews
281.29 every two years after a licensee has had at least one annual review.

281.30 (d) For family adult day services programs, the commissioner may authorize
281.31 licensing reviews every two years after a licensee has had at least one annual review.

281.32 (e) A license issued under this section may be issued for up to two years.

281.33 Sec. 17. Minnesota Statutes 2012, section 245D.02, is amended to read:

281.34 **245D.02 DEFINITIONS.**

282.1 Subdivision 1. **Scope.** The terms used in this chapter have the meanings given
282.2 them in this section.

282.3 Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given
282.4 in section 245A.02, subdivision 2b.

282.5 Subd. 2a. **Authorized representative.** "Authorized representative" means a parent,
282.6 family member, advocate, or other adult authorized by the person or the person's legal
282.7 representative, to serve as a representative in connection with the provision of services
282.8 licensed under this chapter. This authorization must be in writing or by another method
282.9 that clearly indicates the person's free choice. The authorized representative must have no
282.10 financial interest in the provision of any services included in the person's service delivery
282.11 plan and must be capable of providing the support necessary to assist the person in the use
282.12 of home and community-based services licensed under this chapter.

282.13 Subd. 3. **Case manager.** "Case manager" means the individual designated
282.14 to provide waiver case management services, care coordination, or long-term care
282.15 consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,
282.16 or successor provisions.

282.17 Subd. 3a. **Certification.** "Certification" means the commissioner's written
282.18 authorization for a license holder to provide specialized services based on certification
282.19 standards in section 245D.33. The term certification and its derivatives have the same
282.20 meaning and may be substituted for the term licensure and its derivatives in this chapter
282.21 and chapter 245A.

282.22 Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the
282.23 Department of Human Services or the commissioner's designated representative.

282.24 Subd. 4a. **Community residential setting.** "Community residential setting" means
282.25 a residential program as identified in section 245A.11, subdivision 8, where residential
282.26 supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause
282.27 (3), items (i) and (ii), are provided and the license holder is the owner, lessor, or tenant
282.28 of the facility licensed according to this chapter, and the license holder does not reside
282.29 in the facility.

282.30 Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support
282.31 plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision
282.32 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions.

282.33 Subd. 4c. **Coordinated service and support plan addendum.** "Coordinated
282.34 service and support plan addendum" means the documentation that this chapter requires
282.35 of the license holder for each person receiving services.

283.1 Subd. 4d. **Corporate foster care.** "Corporate foster care" means a child foster
283.2 residence setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340,
283.3 or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to
283.4 9555.6265, where the license holder does not live in the home.
283.5 Subd. 4e. **Cultural competence or culturally competent.** "Cultural competence"
283.6 or "culturally competent" means the ability and the will to respond to the unique needs of
283.7 a person that arise from the person's culture and the ability to use the person's culture as a
283.8 resource or tool to assist with the intervention and help meet the person's needs.
283.9 Subd. 4f. **Day services facility.** "Day services facility" means a facility licensed
283.10 according to this chapter at which persons receive day services licensed under this chapter
283.11 from the license holder's direct support staff for a cumulative total of more than 30 days
283.12 within any 12-month period and the license holder is the owner, lessor, or tenant of the
283.13 facility.
283.14 Subd. 5. **Department.** "Department" means the Department of Human Services.
283.15 Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02,
283.16 subdivision 11, and is used interchangeably with the term "direct support service."
283.17 Subd. 6a. **Direct support staff or staff.** "Direct support staff" or "staff" means
283.18 employees of the license holder who have direct contact with persons served by the
283.19 program and includes temporary staff or subcontractors, regardless of employer, providing
283.20 program services for hire under the control of the license holder who have direct contact
283.21 with persons served by the program.
283.22 Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.
283.23 Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary
283.24 daily operation of the program including, but not limited to, fires, severe weather, natural
283.25 disasters, power failures, or other events that threaten the immediate health and safety of
283.26 a person receiving services and that require calling 911, emergency evacuation, moving
283.27 to an emergency shelter, or temporary closure or relocation of the program to another
283.28 facility or service site for more than 24 hours.
283.29 Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual
283.30 restraint" means using a manual restraint when a person poses an imminent risk of
283.31 physical harm to self or others and is the least restrictive intervention that would achieve
283.32 safety. Property damage, verbal aggression, or a person's refusal to receive or participate
283.33 in treatment or programming on their own, do not constitute an emergency.
283.34 Subd. 8b. **Expanded support team.** "Expanded support team" means the members
283.35 of the support team defined in subdivision 46, and a licensed health or mental health
283.36 professional or other licensed, certified, or qualified professionals or consultants working

284.1 with the person and included in the team at the request of the person or the person's legal
284.2 representative.
284.3 Subd. 8c. **Family foster care.** "Family foster care" means a child foster family
284.4 setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult
284.5 foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265,
284.6 where the license holder lives in the home.
284.7 Subd. 9. **Health services.** "Health services" means any service or treatment
284.8 consistent with the physical and mental health needs of the person, such as medication
284.9 administration and monitoring, medical, dental, nutritional, health monitoring, wellness
284.10 education, and exercise.
284.11 Subd. 10. **Home and community-based services.** "Home and community-based
284.12 services" means the services subject to the provisions of this chapter identified in section
284.13 245D.03, subdivision 1, and as defined in:
284.14 (1) the federal federally approved waiver plans governed by United States Code,
284.15 title 42, sections 1396 et seq., or the state's alternative care program according to section
284.16 256B.0913, including the waivers for persons with disabilities under section 256B.49,
284.17 subdivision 11, including the brain injury (BI) waiver, plan; the community alternative
284.18 care (CAC) waiver, plan; the community alternatives for disabled individuals (CADI)
284.19 waiver, plan; the developmental disability (DD) waiver, plan under section 256B.092,
284.20 subdivision 5; the elderly waiver (EW), and plan under section 256B.0915, subdivision 1;
284.21 or successor plans respective to each waiver; or
284.22 (2) the alternative care (AC) program under section 256B.0913.
284.23 Subd. 11. **Incident.** "Incident" means an occurrence that affects the which involves
284.24 a person and requires the program to make a response that is not a part of the program's
284.25 ordinary provision of services to a that person, and includes any of the following:
284.26 (1) serious injury of a person as determined by section 245.91, subdivision 6;
284.27 (2) a person's death;
284.28 (3) any medical emergency, unexpected serious illness, or significant unexpected
284.29 change in an illness or medical condition, or the mental health status of a person that
284.30 requires calling the program to call 911 or a mental health crisis intervention team,
284.31 physician treatment, or hospitalization;
284.32 (4) any mental health crisis that requires the program to call 911 or a mental health
284.33 crisis intervention team;
284.34 (5) an act or situation involving a person that requires the program to call 911,
284.35 law enforcement, or the fire department;
284.36 (4) (6) a person's unauthorized or unexplained absence from a program;

285.1 ~~(5)~~ (7) ~~physical aggression~~ conduct by a person receiving services against another
285.2 person receiving services that ~~causes physical pain, injury, or persistent emotional distress,~~
285.3 ~~including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting,~~
285.4 ~~pushing, and spitting;~~:
285.5 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with
285.6 a person's opportunities to participate in or receive service or support;
285.7 (ii) places the person in actual and reasonable fear of harm;
285.8 (iii) places the person in actual and reasonable fear of damage to property of the
285.9 person; or
285.10 (iv) substantially disrupts the orderly operation of the program;
285.11 ~~(6)~~ (8) any sexual activity between persons receiving services involving force or
285.12 coercion as defined under section 609.341, subdivisions 3 and 14; ~~or~~
285.13 (9) any emergency use of manual restraint as identified in section 245D.061; or
285.14 ~~(7)~~ (10) a report of alleged or suspected child or vulnerable adult maltreatment
285.15 under section 626.556 or 626.557.
285.16 Subd. 11a. **Intermediate care facility for persons with developmental disabilities**
285.17 **or ICF/DD.** "Intermediate care facility for persons with developmental disabilities" or
285.18 "ICF/DD" means a residential program licensed to serve four or more persons with
285.19 developmental disabilities under section 252.28 and chapter 245A and licensed as a
285.20 supervised living facility under chapter 144, which together are certified by the Department
285.21 of Health as an intermediate care facility for persons with developmental disabilities.
285.22 Subd. 11b. **Least restrictive alternative.** "Least restrictive alternative" means
285.23 the alternative method for providing supports and services that is the least intrusive and
285.24 most normalized given the level of supervision and protection required for the person.
285.25 This level of supervision and protection allows risk taking to the extent that there is no
285.26 reasonable likelihood that serious harm will happen to the person or others.
285.27 Subd. 12. **Legal representative.** "Legal representative" means the parent of a
285.28 person who is under 18 years of age, a court-appointed guardian, or other representative
285.29 with legal authority to make decisions about services for a person. Other representatives
285.30 with legal authority to make decisions include but are not limited to a health care agent or
285.31 an attorney-in-fact authorized through a health care directive or power of attorney.
285.32 Subd. 13. **License.** "License" has the meaning given in section 245A.02,
285.33 subdivision 8.
285.34 Subd. 14. **Licensed health professional.** "Licensed health professional" means a
285.35 person licensed in Minnesota to practice those professions described in section 214.01,
285.36 subdivision 2.

Subd. 15. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 16. **Medication.** "Medication" means a prescription drug or over-the-counter drug. For purposes of this chapter, "medication" includes dietary supplements.

~~Subd. 17.~~ ~~**Medication administration.**~~ ~~"Medication administration" means performing the following set of tasks to ensure a person takes both prescription and over-the-counter medications and treatments according to orders issued by appropriately licensed professionals, and includes the following:~~

~~(1) checking the person's medication record;~~

~~(2) preparing the medication for administration;~~

~~(3) administering the medication to the person;~~

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

~~(5) reporting to the prescriber or a nurse any concerns about the medication, including side effects, adverse reactions, effectiveness, or the person's refusal to take the medication or the person's self-administration of the medication.~~

~~Subd. 18.~~ ~~**Medication assistance.**~~ ~~"Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, which includes either of the following:~~

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

~~(2) providing verbal or visual reminders to perform regularly scheduled treatments and exercises.~~

~~Subd. 19.~~ ~~**Medication management.**~~ ~~"Medication management" means the provision of any of the following:~~

~~(1) medication-related services to a person;~~

~~(2) medication setup;~~

~~(3) medication administration;~~

~~(4) medication storage and security;~~

~~(5) medication documentation and charting;~~

~~(6) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;~~

~~(7) coordination of medication refills;~~

~~(8) handling changes to prescriptions and implementation of those changes;~~

287.1 (9) communicating with the pharmacy; or
287.2 (10) coordination and communication with prescriber.
287.3 For the purposes of this chapter, medication management does not mean "medication
287.4 therapy management services" as identified in section 256B.0625, subdivision 13h.
287.5 Subd. 20. **Mental health crisis intervention team.** "Mental health crisis
287.6 intervention team" means a mental health crisis response providers provider as identified
287.7 in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944,
287.8 subdivision 1, paragraph (d), for children.
287.9 Subd. 20a. **Most integrated setting.** "Most integrated setting" means a setting that
287.10 enables individuals with disabilities to interact with nondisabled persons to the fullest
287.11 extent possible.
287.12 Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that
287.13 is not required by federal law to bear the statement "Caution: Federal law prohibits
287.14 dispensing without prescription."
287.15 Subd. 21a. **Outcome.** "Outcome" means the behavior, action, or status attained by
287.16 the person that can be observed, measured, and determined reliable and valid.
287.17 Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision
287.18 11.
287.19 Subd. 23. **Person with a disability.** "Person with a disability" means a person
287.20 determined to have a disability by the commissioner's state medical review team as
287.21 identified in section 256B.055, subdivision 7, the Social Security Administration, or
287.22 the person is determined to have a developmental disability as defined in Minnesota
287.23 Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section
287.24 252.27, subdivision 1a.
287.25 Subd. 23a. **Physician.** "Physician" means a person who is licensed under chapter
287.26 147.
287.27 Subd. 24. **Prescriber.** "Prescriber" means a licensed practitioner as defined in
287.28 section 151.01, subdivision 23, person who is authorized under section sections 148.235;
287.29 151.01, subdivision 23; or 151.37 to prescribe drugs. For the purposes of this chapter, the
287.30 term "prescriber" is used interchangeably with "physician."
287.31 Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section
287.32 151.01, subdivision 17 16.
287.33 Subd. 26. **Program.** "Program" means either the nonresidential or residential
287.34 program as defined in section 245A.02, subdivisions 10 and 14.
287.35 Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any
287.36 medication prescribed to treat the symptoms of mental illness that affect thought processes,

mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

Subd. 28. **Restraint.** "Restraint" means physical or mechanical limiting of the free and normal movement of body or limbs.

Subd. 29. **Seclusion.** "Seclusion" means ~~separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if he or she chooses~~ the placement of a person alone in a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room.

Subd. 29a. **Self-determination.** "Self-determination" means the person makes decisions independently, plans for the person's own future, determines how money is spent for the person's supports, and takes responsibility for making these decisions. If a person has a legal representative, the legal representative's decision-making authority is limited to the scope of authority granted by the court or allowed in the document authorizing the legal representative to act.

Subd. 29b. **Semi-independent living services.** "Semi-independent living services" has the meaning given in section 252.275.

Subd. 30. **Service.** "Service" means care, training, supervision, counseling, consultation, or medication assistance assigned to the license holder in the coordinated service and support plan.

~~Subd. 31. **Service plan.** "Service plan" means the individual service plan or individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions, and includes any support plans or service needs identified as a result of long-term care consultation, or a support team meeting that includes the participation of the person, the person's legal representative, and case manager, or assigned to a license holder through an authorized service agreement.~~

Subd. 32. **Service site.** "Service site" means the location where the service is provided to the person, including, but not limited to, a facility licensed according to chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's own home; or a community-based location.

~~Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a person served by the facility, agency, or program.~~

289.1 Subd. 33a. **Supervised living facility.** "Supervised living facility" has the meaning
289.2 given in Minnesota Rules, part 4665.0100, subpart 10.

289.3 Subd. 33b. **Supervision.** (a) "Supervision" means:

289.4 (1) oversight by direct support staff as specified in the person's coordinated service
289.5 and support plan or coordinated service and support plan addendum and awareness of
289.6 the person's needs and activities;

289.7 (2) responding to situations that present a serious risk to the health, safety, or rights
289.8 of the person while services are being provided; and

289.9 (3) the presence of direct support staff at a service site while services are being
289.10 provided, unless a determination has been made and documented in the person's coordinated
289.11 service and support plan or coordinated service and support plan addendum that the person
289.12 does not require the presence of direct support staff while services are being provided.

289.13 (b) For the purposes of this definition, "while services are being provided," means
289.14 any period of time during which the license holder will seek reimbursement for services.

289.15 Subd. 34. **Support team.** "Support team" means the service planning team
289.16 identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in
289.17 Minnesota Rules, part 9525.0004, subpart 14.

289.18 Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an
289.19 ongoing activity to a room, either locked or unlocked, or otherwise separating a person
289.20 from others in a way that prevents social contact and prevents the person from leaving
289.21 the situation if the person chooses. For the purpose of chapter 245D, "time out" does
289.22 not mean voluntary removal or self-removal for the purpose of calming, prevention of
289.23 escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out"
289.24 does not include a person voluntarily moving from an ongoing activity to an unlocked
289.25 room or otherwise separating from a situation or social contact with others if the person
289.26 chooses. For the purposes of this definition, "voluntarily" means without being forced,
289.27 compelled, or coerced.

289.28 ~~Subd. 35.~~ ~~**Unit of government.**~~ ~~"Unit of government" means every city, county,~~
289.29 ~~town, school district, other political subdivisions of the state, and any agency of the state~~
289.30 ~~or the United States, and includes any instrumentality of a unit of government.~~

289.31 Subd. 35a. **Treatment.** "Treatment" means the provision of care, other than
289.32 medications, ordered or prescribed by a licensed health or mental health professional,
289.33 provided to a person to cure, rehabilitate, or ease symptoms.

289.34 Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the
289.35 license holder, provides direct services without pay to a person served by the license holder.

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

290.1 Sec. 18. Minnesota Statutes 2012, section 245D.03, is amended to read:

290.2 **245D.03 APPLICABILITY AND EFFECT.**

290.3 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of
290.4 home and community-based services to persons with disabilities and persons age 65 and
290.5 older pursuant to this chapter. The licensing standards in this chapter govern the provision
290.6 of ~~the following~~ basic support services~~:~~ and intensive support services.

290.7 ~~(1) housing access coordination as defined under the current BI, CADI, and DD~~
290.8 ~~waiver plans or successor plans;~~

290.9 ~~(2) respite services as defined under the current CADI, BI, CAC, DD, and EW~~
290.10 ~~waiver plans or successor plans when the provider is an individual who is not an employee~~
290.11 ~~of a residential or nonresidential program licensed by the Department of Human Services~~
290.12 ~~or the Department of Health that is otherwise providing the respite service;~~

290.13 ~~(3) behavioral programming as defined under the current BI and CADI waiver~~
290.14 ~~plans or successor plans;~~

290.15 ~~(4) specialist services as defined under the current DD waiver plan or successor plans;~~

290.16 ~~(5) companion services as defined under the current BI, CADI, and EW waiver~~
290.17 ~~plans or successor plans, excluding companion services provided under the Corporation~~
290.18 ~~for National and Community Services Senior Companion Program established under the~~
290.19 ~~Domestic Volunteer Service Act of 1973, Public Law 98-288;~~

290.20 ~~(6) personal support as defined under the current DD waiver plan or successor plans;~~

290.21 ~~(7) 24-hour emergency assistance, on-call and personal emergency response as~~
290.22 ~~defined under the current CADI and DD waiver plans or successor plans;~~

290.23 ~~(8) night supervision services as defined under the current BI waiver plan or~~
290.24 ~~successor plans;~~

290.25 ~~(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW~~
290.26 ~~waiver plans or successor plans, excluding providers licensed by the Department of Health~~
290.27 ~~under chapter 144A and those providers providing cleaning services only;~~

290.28 ~~(10) independent living skills training as defined under the current BI and CADI~~
290.29 ~~waiver plans or successor plans;~~

290.30 ~~(11) prevocational services as defined under the current BI and CADI waiver plans~~
290.31 ~~or successor plans;~~

290.32 ~~(12) structured day services as defined under the current BI waiver plan or successor~~
290.33 ~~plans; or~~

290.34 ~~(13) supported employment as defined under the current BI and CADI waiver plans~~
290.35 ~~or successor plans.~~

291.1 (b) Basic support services provide the level of assistance, supervision, and care that
291.2 is necessary to ensure the health and safety of the person and do not include services that
291.3 are specifically directed toward the training, treatment, habilitation, or rehabilitation of
291.4 the person. Basic support services include:

291.5 (1) in-home and out-of-home respite care services as defined in section 245A.02,
291.6 subdivision 15, and under the brain injury, community alternative care, community
291.7 alternatives for disabled individuals, developmental disability, and elderly waiver plans;

291.8 (2) companion services as defined under the brain injury, community alternatives for
291.9 disabled individuals, and elderly waiver plans, excluding companion services provided
291.10 under the Corporation for National and Community Services Senior Companion Program
291.11 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

291.12 (3) personal support as defined under the developmental disability waiver plan;

291.13 (4) 24-hour emergency assistance, personal emergency response as defined under the
291.14 community alternatives for disabled individuals and developmental disability waiver plans;

291.15 (5) night supervision services as defined under the brain injury waiver plan; and

291.16 (6) homemaker services as defined under the community alternatives for disabled
291.17 individuals, brain injury, community alternative care, developmental disability, and elderly
291.18 waiver plans, excluding providers licensed by the Department of Health under chapter
291.19 144A and those providers providing cleaning services only.

291.20 (c) Intensive support services provide assistance, supervision, and care that is
291.21 necessary to ensure the health and safety of the person and services specifically directed
291.22 toward the training, habilitation, or rehabilitation of the person. Intensive support services
291.23 include:

291.24 (1) intervention services, including:

291.25 (i) behavioral support services as defined under the brain injury and community
291.26 alternatives for disabled individuals waiver plans;

291.27 (ii) in-home or out-of-home crisis respite services as defined under the developmental
291.28 disability waiver plan; and

291.29 (iii) specialist services as defined under the current developmental disability waiver
291.30 plan;

291.31 (2) in-home support services, including:

291.32 (i) in-home family support and supported living services as defined under the
291.33 developmental disability waiver plan;

291.34 (ii) independent living services training as defined under the brain injury and
291.35 community alternatives for disabled individuals waiver plans; and

291.36 (iii) semi-independent living services;

292.1 (3) residential supports and services, including:

292.2 (i) supported living services as defined under the developmental disability waiver
292.3 plan provided in a family or corporate child foster care residence, a family adult foster
292.4 care residence, a community residential setting, or a supervised living facility;

292.5 (ii) foster care services as defined in the brain injury, community alternative care,
292.6 and community alternatives for disabled individuals waiver plans provided in a family or
292.7 corporate child foster care residence, a family adult foster care residence, or a community
292.8 residential setting; and

292.9 (iii) residential services provided in a supervised living facility that is certified by
292.10 the Department of Health as an ICF/DD;

292.11 (4) day services, including:

292.12 (i) structured day services as defined under the brain injury waiver plan;

292.13 (ii) day training and habilitation services under sections 252.40 to 252.46, and as
292.14 defined under the developmental disability waiver plan; and

292.15 (iii) prevocational services as defined under the brain injury and community
292.16 alternatives for disabled individuals waiver plans; and

292.17 (5) supported employment as defined under the brain injury, developmental
292.18 disability, and community alternatives for disabled individuals waiver plans.

292.19 Subd. 2. **Relationship to other standards governing home and community-based**
292.20 **services.** (a) A license holder governed by this chapter is also subject to the licensure
292.21 requirements under chapter 245A.

292.22 (b) ~~A license holder concurrently providing child foster care services licensed~~
292.23 ~~according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed~~
292.24 ~~under this chapter is exempt from section 245D.04 as it applies to the person.~~ A corporate
292.25 or family child foster care site controlled by a license holder and providing services
292.26 governed by this chapter is exempt from compliance with section 245D.04. This exemption
292.27 applies to foster care homes where at least one resident is receiving residential supports
292.28 and services licensed according to this chapter. This chapter does not apply to corporate or
292.29 family child foster care homes that do not provide services licensed under this chapter.

292.30 (c) A family adult foster care site controlled by a license holder and providing
292.31 services governed by this chapter is exempt from compliance with Minnesota Rules, parts
292.32 9555.6185; 9555.6225, subpart 8; 9555.6235, item C; 9555.6245; 9555.6255, subpart
292.33 2; and 9555.6265. These exemptions apply to family adult foster care homes where at
292.34 least one resident is receiving residential supports and services licensed according to this
292.35 chapter. This chapter does not apply to family adult foster care homes that do not provide
292.36 services licensed under this chapter.

(d) A license holder providing services licensed according to this chapter in a supervised living facility is exempt from compliance with sections 245D.04; 245D.05, subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5).

(e) A license holder providing residential services to persons in an ICF/DD is exempt from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09, subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

~~(c)~~ (f) A license holder ~~concurrently~~ providing ~~home care~~ homemaker services ~~registered~~ licensed according to ~~sections 144A.43 to 144A.49 to the same person receiving home management services licensed under~~ this chapter and registered according to chapter 144A is exempt from compliance with section 245D.04 ~~as it applies to the person~~.

~~(d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557, subdivision 14, paragraph (b).~~

~~(e) Notwithstanding section 245D.06, subdivision 5, a license holder providing structured day, prevocational, or supported employment services under this chapter and day training and habilitation or supported employment services licensed under chapter 245B within the same program is exempt from compliance with this chapter when the license holder notifies the commissioner in writing that the requirements under chapter 245B will be met for all persons receiving these services from the program. For the purposes of this paragraph, if the license holder has obtained approval from the commissioner for an alternative inspection status according to section 245B.031, that approval will apply to all persons receiving services in the program.~~

(g) Nothing in this chapter prohibits a license holder from concurrently serving persons without disabilities or people who are or are not age 65 and older, provided this chapter's standards are met as well as other relevant standards.

(h) The documentation required under sections 245D.07 and 245D.071 must meet the individual program plan requirements identified in section 256B.092 or successor provisions.

Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant a variance to any of the requirements in this chapter, except sections 245D.04, ~~and 245D.10, subdivision 4, paragraph (b)~~ 245D.06, subdivision 4, paragraph (b), and 245D.061, subdivision 3, or provisions governing data practices and information rights of persons.

294.1 ~~Subd. 4.~~ ~~**License holders with multiple 245D licenses.**~~ ~~(a) When a person changes~~
294.2 ~~service from one license to a different license held by the same license holder, the license~~
294.3 ~~holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).~~
294.4 ~~(b) When a staff person begins providing direct service under one or more licenses~~
294.5 ~~held by the same license holder, other than the license for which staff orientation was~~
294.6 ~~initially provided according to section 245D.09, subdivision 4, the license holder is~~
294.7 ~~exempt from those staff orientation requirements, except the staff person must review each~~
294.8 ~~person's service plan and medication administration procedures in accordance with section~~
294.9 ~~245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.~~
294.10 Subd. 4. **Program certification.** An applicant or a license holder may apply for
294.11 program certification as identified in section 245D.33.

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

294.13 Sec. 19. Minnesota Statutes 2012, section 245D.04, is amended to read:

294.14 **245D.04 SERVICE RECIPIENT RIGHTS.**

294.15 Subdivision 1. **License holder responsibility for individual rights of persons**
294.16 **served by the program.** The license holder must:
294.17 (1) provide each person or each person's legal representative with a written notice
294.18 that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of
294.19 those rights within five working days of service initiation and annually thereafter;
294.20 (2) make reasonable accommodations to provide this information in other formats
294.21 or languages as needed to facilitate understanding of the rights by the person and the
294.22 person's legal representative, if any;
294.23 (3) maintain documentation of the person's or the person's legal representative's
294.24 receipt of a copy and an explanation of the rights; and
294.25 (4) ensure the exercise and protection of the person's rights in the services provided
294.26 by the license holder and as authorized in the coordinated service and support plan.
294.27 Subd. 2. **Service-related rights.** A person's service-related rights include the right to:
294.28 (1) participate in the development and evaluation of the services provided to the
294.29 person;
294.30 (2) have services and supports identified in the coordinated service and support plan
294.31 and the coordinated service and support plan addendum provided in a manner that respects
294.32 and takes into consideration the person's preferences according to the requirements in
294.33 sections 245D.07 and 245D.071;

295.1 (3) refuse or terminate services and be informed of the consequences of refusing
295.2 or terminating services;
295.3 (4) know, in advance, limits to the services available from the license holder,
295.4 including the license holder's knowledge, skill, and ability to meet the person's service and
295.5 support needs based on the information required in section 245D.031, subdivision 2;
295.6 (5) know conditions and terms governing the provision of services, including the
295.7 license holder's admission criteria and policies and procedures related to temporary
295.8 service suspension and service termination;
295.9 (6) a coordinated transfer to ensure continuity of care when there will be a change
295.10 in the provider;
295.11 (7) know what the charges are for services, regardless of who will be paying for the
295.12 services, and be notified of changes in those charges;
295.13 ~~(7)~~ (8) know, in advance, whether services are covered by insurance, government
295.14 funding, or other sources, and be told of any charges the person or other private party
295.15 may have to pay; and
295.16 ~~(8)~~ (9) receive services from an individual who is competent and trained, who has
295.17 professional certification or licensure, as required, and who meets additional qualifications
295.18 identified in the person's coordinated service and support plan~~.~~ or coordinated service and
295.19 support plan addendum.
295.20 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include
295.21 the right to:
295.22 (1) have personal, financial, service, health, and medical information kept private,
295.23 and be advised of disclosure of this information by the license holder;
295.24 (2) access records and recorded information about the person in accordance with
295.25 applicable state and federal law, regulation, or rule;
295.26 (3) be free from maltreatment;
295.27 (4) be free from restraint, time out, or seclusion ~~used for a purpose other than~~ except
295.28 for emergency use of manual restraint to protect the person from imminent danger to self
295.29 or others according to the requirements in section 245D.06;
295.30 (5) receive services in a clean and safe environment when the license holder is the
295.31 owner, lessor, or tenant of the service site;
295.32 (6) be treated with courtesy and respect and receive respectful treatment of the
295.33 person's property;
295.34 (7) reasonable observance of cultural and ethnic practice and religion;
295.35 (8) be free from bias and harassment regarding race, gender, age, disability,
295.36 spirituality, and sexual orientation;

296.1 (9) be informed of and use the license holder's grievance policy and procedures,
296.2 including knowing how to contact persons responsible for addressing problems and to
296.3 appeal under section 256.045;
296.4 (10) know the name, telephone number, and the Web site, e-mail, and street
296.5 addresses of protection and advocacy services, including the appropriate state-appointed
296.6 ombudsman, and a brief description of how to file a complaint with these offices;
296.7 (11) assert these rights personally, or have them asserted by the person's family,
296.8 authorized representative, or legal representative, without retaliation;
296.9 (12) give or withhold written informed consent to participate in any research or
296.10 experimental treatment;
296.11 (13) associate with other persons of the person's choice;
296.12 (14) personal privacy; and
296.13 (15) engage in chosen activities.
296.14 (b) For a person residing in a residential site licensed according to chapter 245A,
296.15 or where the license holder is the owner, lessor, or tenant of the residential service site,
296.16 protection-related rights also include the right to:
296.17 (1) have daily, private access to and use of a non-coin-operated telephone for local
296.18 calls and long-distance calls made collect or paid for by the person;
296.19 (2) receive and send, without interference, uncensored, unopened mail or electronic
296.20 correspondence or communication; ~~and~~
296.21 (3) have use of and free access to common areas in the residence; and
296.22 (4) privacy for visits with the person's spouse, next of kin, legal counsel, religious
296.23 advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including
296.24 privacy in the person's bedroom.
296.25 (c) Restriction of a person's rights under subdivision 2, clause (10), or paragraph (a),
296.26 clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure
296.27 the health, safety, and well-being of the person. Any restriction of those rights must be
296.28 documented in the person's coordinated service and support plan ~~for the person and~~ or
296.29 coordinated service and support plan addendum. The restriction must be implemented
296.30 in the least restrictive alternative manner necessary to protect the person and provide
296.31 support to reduce or eliminate the need for the restriction in the most integrated setting
296.32 and inclusive manner. The documentation must include the following information:
296.33 (1) the justification for the restriction based on an assessment of the person's
296.34 vulnerability related to exercising the right without restriction;
296.35 (2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur~~, at a minimum, every three months for persons who do not have a legal representative and annually for persons who do have a legal representative~~ semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

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

Sec. 20. Minnesota Statutes 2012, section 245D.05, is amended to read:

245D.05 HEALTH SERVICES.

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

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

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

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

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

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

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

298.15 Subd. 1b. **Medication assistance.** If responsibility for medication assistance
298.16 is assigned to the license holder in the coordinated service and support plan or the
298.17 coordinated service and support plan addendum, the license holder must ensure that
298.18 the requirements of subdivision 2, paragraph (b), have been met when staff provides
298.19 medication assistance to enable a person to self-administer medication or treatment when
298.20 the person is capable of directing the person's own care, or when the person's legal
298.21 representative is present and able to direct care for the person. For the purposes of this
298.22 subdivision, "medication assistance" means any of the following:

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

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

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

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

298.34 (1) checking the person's medication record;

298.35 (2) preparing the medication as necessary;

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

299.1 (4) documenting the administration of the medication or treatment or the reason for
299.2 not administering the medication or treatment; and
299.3 (5) reporting to the prescriber or a nurse any concerns about the medication or
299.4 treatment, including side effects, effectiveness, or a pattern of the person refusing to
299.5 take the medication or treatment as prescribed. Adverse reactions must be immediately
299.6 reported to the prescriber or a nurse.
299.7 (b)(1) The license holder must ensure that the following criteria requirements in
299.8 clauses (2) to (4) have been met before staff that is not a licensed health professional
299.9 administers administering medication or treatment:.
299.10 (1) (2) The license holder must obtain written authorization has been obtained from
299.11 the person or the person's legal representative to administer medication or treatment
299.12 orders; and must obtain reauthorization annually as needed. If the person or the person's
299.13 legal representative refuses to authorize the license holder to administer medication, the
299.14 medication must not be administered. The refusal to authorize medication administration
299.15 must be reported to the prescriber as expediently as possible.
299.16 (2) (3) The staff person has completed responsible for administering the medication
299.17 or treatment must complete medication administration training according to section
299.18 245D.09, subdivision 4, paragraph 4a, paragraphs (a) and (c), clause (2); and, as applicable
299.19 to the person, paragraph (d).
299.20 (3) The medication or treatment will be administered under administration
299.21 procedures established for the person in consultation with a licensed health professional.
299.22 written instruction from the person's physician may constitute the medication
299.23 administration procedures. A prescription label or the prescriber's order for the
299.24 prescription is sufficient to constitute written instructions from the prescriber. A licensed
299.25 health professional may delegate medication administration procedures.
299.26 (4) For a license holder providing intensive support services, the medication or
299.27 treatment must be administered according to the license holder's medication administration
299.28 policy and procedures as required under section 245D.11, subdivision 2, clause (3).
299.29 (b) (c) The license holder must ensure the following information is documented in
299.30 the person's medication administration record:
299.31 (1) the information on the current prescription label or the prescriber's current written
299.32 or electronically recorded order or prescription that includes directions for the person's
299.33 name, description of the medication or treatment to be provided, and the frequency and
299.34 other information needed to safely and correctly administering administer the medication
299.35 or treatment to ensure effectiveness;

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

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

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

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

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

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

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

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

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

Subd. 4. **Reviewing and reporting medication and treatment issues.** ~~The following medication administration issues must be reported to the person or the person's legal representative and case manager as they occur or following timelines established in the person's service plan or as requested in writing by the person or the person's legal representative, or the case manager:~~ (a) When assigned responsibility for medication administration, the license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed to identify

301.1 medication administration errors. At a minimum, the review must be conducted every
301.2 three months, or more frequently as directed in the coordinated service and support plan
301.3 or coordinated service and support plan addendum or as requested by the person or the
301.4 person's legal representative. Based on the review, the license holder must develop and
301.5 implement a plan to correct patterns of medication administration errors when identified.

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

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

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

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

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

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

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

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

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

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

301.31 Sec. 21. **[245D.051] PSYCHOTROPIC MEDICATION USE AND**
301.32 **MONITORING.**

301.33 Subdivision 1. **Conditions for psychotropic medication administration.** (a)
301.34 When a person is prescribed a psychotropic medication and the license holder is assigned
301.35 responsibility for administration of the medication in the person's coordinated service

302.1 and support plan or the coordinated service and support plan addendum, the license
302.2 holder must ensure that the requirements in paragraphs (b) to (d) and section 245D.05,
302.3 subdivision 2, are met.

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

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

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

302.12 (2) documentation methods the license holder will use to monitor and measure
302.13 changes in the target symptoms that are to be alleviated by the psychotropic medication if
302.14 required by the prescriber. The license holder must collect and report on medication and
302.15 symptom-related data as instructed by the prescriber. The license holder must provide
302.16 the monitoring data to the expanded support team for review every three months, or as
302.17 otherwise requested by the person or the person's legal representative.

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

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

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

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

303.1 Sec. 22. Minnesota Statutes 2012, section 245D.06, is amended to read:

303.2 **245D.06 PROTECTION STANDARDS.**

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

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

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

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

303.23 (e) The license holder must report the death or serious injury of the person ~~to the legal~~
303.24 ~~representative, if any, and case manager,~~ as required in paragraph (b) and to the Department
303.25 of Human Services Licensing Division, and the Office of Ombudsman for Mental Health
303.26 and Developmental Disabilities as required under section 245.94, subdivision 2a, within
303.27 24 hours of the death, or receipt of information that the death occurred, unless the license
303.28 holder has reason to know that the death has already been reported.

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

303.35 ~~(f)~~ (g) The license holder must conduct ~~a~~ an internal review of incident reports of
303.36 deaths and serious injuries that occurred while services were being provided and that

304.1 were not reported by the program as alleged or suspected maltreatment, for identification
304.2 of incident patterns, and implementation of corrective action as necessary to reduce
304.3 occurrences. The review must include an evaluation of whether related policies and
304.4 procedures were followed, whether the policies and procedures were adequate, whether
304.5 there is a need for additional staff training, whether the reported event is similar to past
304.6 events with the persons or the services involved, and whether there is a need for corrective
304.7 action by the license holder to protect the health and safety of persons receiving services.
304.8 Based on the results of this review, the license holder must develop, document, and
304.9 implement a corrective action plan designed to correct current lapses and prevent future
304.10 lapses in performance by staff or the license holder, if any.

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

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

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

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

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

304.31 (iii) doors are locked from the inside to prevent a person from exiting only when
304.32 necessary to protect the safety of a person receiving services and not as a substitute for
304.33 staff supervision or interactions with the person. If doors are locked from the inside, the
304.34 license holder must document an assessment of the physical plant, the environment and
304.35 the population served, identifying the risk factors which require the use of locked doors,

305.1 and a statement of specific measures to be taken to minimize the safety risk to persons
305.2 receiving services at the service site; and
305.3 (iii) (iv) a staff person is available on site who is trained in basic first aid and, when
305.4 required in a person's coordinated service and support plan or coordinated service and
305.5 support plan addendum, cardiopulmonary resuscitation, whenever persons are present and
305.6 staff are required to be at the site to provide direct service. The training must include
305.7 in-person instruction, hands-on practice, and an observed skills assessment under the
305.8 direct supervision of a first aid instructor;
305.9 (2) maintain equipment, vehicles, supplies, and materials owned or leased by the
305.10 license holder in good condition when used to provide services;
305.11 (3) follow procedures to ensure safe transportation, handling, and transfers of the
305.12 person and any equipment used by the person, when the license holder is responsible for
305.13 transportation of a person or a person's equipment;
305.14 (4) be prepared for emergencies and follow emergency response procedures to
305.15 ensure the person's safety in an emergency; and
305.16 (5) follow universal precautions and sanitary practices, including hand washing, for
305.17 infection prevention and control, and to prevent communicable diseases.
305.18 Subd. 3. **Compliance with fire and safety codes.** When services are provided at a
305.19 service site licensed according to chapter 245A or where the license holder is the owner,
305.20 lessor, or tenant of the service site, the license holder must document compliance with
305.21 applicable building codes, fire and safety codes, health rules, and zoning ordinances, or
305.22 document that an appropriate waiver has been granted.
305.23 Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person
305.24 with the safekeeping of funds or other property according to section 245A.04, subdivision
305.25 13, the license holder must have obtain written authorization to do so from the person or
305.26 the person's legal representative and the case manager. Authorization must be obtained
305.27 within five working days of service initiation and renewed annually thereafter. At the time
305.28 initial authorization is obtained, the license holder must survey, document, and implement
305.29 the preferences of the person or the person's legal representative and the case manager
305.30 for frequency of receiving a statement that itemizes receipts and disbursements of funds
305.31 or other property. The license holder must document changes to these preferences when
305.32 they are requested.
305.33 (b) A license holder or staff person may not accept powers-of-attorney from a
305.34 person receiving services from the license holder for any purpose, and may not accept an
305.35 appointment as guardian or conservator of a person receiving services from the license
305.36 holder. This does not apply to license holders that are Minnesota counties or other

units of government or to staff persons employed by license holders who were acting as ~~power-of-attorney, guardian, or conservator~~ attorney-in-fact for specific individuals prior to ~~April 23, 2012~~ implementation of this chapter. The license holder must maintain documentation of the power-of-attorney~~, guardianship, or conservatorship~~ in the service recipient record.

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

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

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

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

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

307.1 warn staff that a person is leaving a room or area do not, in and of themselves, restrict
307.2 freedom of movement and should not be considered restraints.

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

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

307.13 Sec. 23. **[245D.061] EMERGENCY USE OF MANUAL RESTRAINTS.**

307.14 Subdivision 1. **Standards for emergency use of manual restraints.** Except
307.15 for the emergency use of controlled procedures with a person with a developmental
307.16 disability as governed by Minnesota Rules, part 9525.2770, or its successor provisions,
307.17 the license holder must ensure that emergency use of manual restraints complies with the
307.18 requirements of this chapter and the license holder's policy and procedures as required
307.19 under subdivision 10.

307.20 Subd. 2. **Definitions.** (a) The terms used in this section have the meaning given
307.21 them in this subdivision.

307.22 (b) "Manual restraint" means physical intervention intended to hold a person
307.23 immobile or limit a person's voluntary movement by using body contact as the only source
307.24 of physical restraint.

307.25 (c) "Mechanical restraint" means the use of devices, materials, or equipment attached
307.26 or adjacent to the person's body, or the use of practices which restrict freedom of movement
307.27 or normal access to one's body or body parts, or limits a person's voluntary movement
307.28 or holds a person immobile as an intervention precipitated by a person's behavior. The
307.29 term does apply to mechanical restraint used to prevent injury with persons who engage in
307.30 self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue
307.31 damage that have caused or could cause medical problems resulting from the self-injury.

307.32 Subd. 3. **Conditions for emergency use of manual restraint.** Emergency use of
307.33 manual restraint must meet the following conditions:

307.34 (1) immediate intervention must be needed to protect the person or others from
307.35 imminent risk of physical harm; and

308.1 (2) the type of manual restraint used must be the least restrictive intervention to
308.2 eliminate the immediate risk of harm and effectively achieve safety. The manual restraint
308.3 must end when the threat of harm ends.

308.4 Subd. 4. **Permitted instructional techniques and therapeutic conduct.** (a) Use of
308.5 physical contact as therapeutic conduct or as an instructional technique as identified in
308.6 paragraphs (b) and (c), is permitted and is not subject to the requirements of this section
308.7 when such use is addressed in a person's coordinated service and support plan addendum
308.8 and the required conditions have been met. For the purposes of this subdivision,
308.9 "therapeutic conduct" has the meaning given in section 626.5572, subdivision 20.

308.10 (b) Physical contact or instructional techniques must use the least restrictive
308.11 alternative possible to meet the needs of the person and may be used:

308.12 (1) to calm or comfort a person by holding that person with no resistance from
308.13 that person;

308.14 (2) to protect a person known to be at risk of injury due to frequent falls as a result of
308.15 a medical condition; or

308.16 (3) to position a person with physical disabilities in a manner specified in the
308.17 person's coordinated service and support plan addendum.

308.18 (c) Restraint may be used as therapeutic conduct:

308.19 (1) to allow a licensed health care professional to safely conduct a medical
308.20 examination or to provide medical treatment ordered by a licensed health care professional
308.21 to a person necessary to promote healing or recovery from an acute, meaning short-term,
308.22 medical condition;

308.23 (2) to facilitate the person's completion of a task or response when the person does
308.24 not resist or the person's resistance is minimal in intensity and duration;

308.25 (3) to briefly block or redirect a person's limbs or body without holding the person
308.26 or limiting the person's movement to interrupt the person's behavior that may result in
308.27 injury to self or others; or

308.28 (4) to assist in the safe evacuation of a person in the event of an emergency or to
308.29 redirect a person who is at imminent risk of harm in a dangerous situation.

308.30 (d) A plan for using restraint as therapeutic conduct must be developed according to
308.31 the requirements in sections 245D.07 and 245D.071, and must include methods to reduce
308.32 or eliminate the use of and need for restraint.

308.33 Subd. 5. **Restrictions when implementing emergency use of manual restraint.**
308.34 (a) Emergency use of manual restraint procedures must not:

308.35 (1) be implemented with a child in a manner that constitutes sexual abuse, neglect,
308.36 physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

309.1 (2) be implemented with an adult in a manner that constitutes abuse or neglect as
309.2 defined in section 626.5572, subdivisions 2 and 17;
309.3 (3) be implemented in a manner that violates a person's rights and protections
309.4 identified in section 245D.04;
309.5 (4) restrict a person's normal access to a nutritious diet, drinking water, adequate
309.6 ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping
309.7 conditions, or necessary clothing, or to any protection required by state licensing standards
309.8 and federal regulations governing the program;
309.9 (5) deny the person visitation or ordinary contact with legal counsel, a legal
309.10 representative, or next of kin;
309.11 (6) be used as a substitute for adequate staffing, for the convenience of staff, as
309.12 punishment, or as a consequence if the person refuses to participate in the treatment
309.13 or services provided by the program; or
309.14 (7) use prone restraint. For the purposes of this section, "prone restraint" means use
309.15 of manual restraint that places a person in a face-down position. This does not include
309.16 brief physical holding of a person who, during an emergency use of manual restraint, rolls
309.17 into a prone position, and the person is restored to a standing, sitting, or side-lying position
309.18 as quickly as possible. Applying back or chest pressure while a person is in the prone or
309.19 supine position or face-up is prohibited.
309.20 Subd. 6. **Monitoring emergency use of manual restraint.** The license holder shall
309.21 monitor a person's health and safety during an emergency use of a manual restraint. Staff
309.22 monitoring the procedure must not be the staff implementing the procedure when possible.
309.23 The license holder shall complete a monitoring form, approved by the commissioner, for
309.24 each incident involving the emergency use of a manual restraint.
309.25 Subd. 7. **Reporting emergency use of manual restraint incident.** (a) Within
309.26 three calendar days after an emergency use of a manual restraint, the staff person who
309.27 implemented the emergency use must report in writing to the designated coordinator the
309.28 following information about the emergency use:
309.29 (1) the staff and persons receiving services who were involved in the incident
309.30 leading up to the emergency use of manual restraint;
309.31 (2) a description of the physical and social environment, including who was present
309.32 before and during the incident leading up to the emergency use of manual restraint;
309.33 (3) a description of what less restrictive alternative measures were attempted to
309.34 de-escalate the incident and maintain safety before the manual restraint was implemented
309.35 that identifies when, how, and how long the alternative measures were attempted before
309.36 manual restraint was implemented;

310.1 (4) a description of the mental, physical, and emotional condition of the person who
310.2 was restrained, and other persons involved in the incident leading up to, during, and
310.3 following the manual restraint;

310.4 (5) whether there was any injury to the person who was restrained or other persons
310.5 involved in the incident, including staff, before or as a result of the use of manual
310.6 restraint; and

310.7 (6) whether there was an attempt to debrief with the staff, and, if not contraindicated,
310.8 with the person who was restrained and other persons who were involved in or who
310.9 witnessed the restraint, following the incident and the outcome of the debriefing. If the
310.10 debriefing was not conducted at the time the incident report was made, the report should
310.11 identify whether a debriefing is planned.

310.12 (b) Each single incident of emergency use of manual restraint must be reported
310.13 separately. For the purposes of this subdivision, an incident of emergency use of manual
310.14 restraint is a single incident when the following conditions have been met:

310.15 (1) after implementing the manual restraint, staff attempt to release the person at the
310.16 moment staff believe the person's conduct no longer poses an imminent risk of physical
310.17 harm to self or others and less restrictive strategies can be implemented to maintain safety;

310.18 (2) upon the attempt to release the restraint, the person's behavior immediately
310.19 re-escalates; and

310.20 (3) staff must immediately reimplement the restraint in order to maintain safety.

310.21 Subd. 8. **Internal review of emergency use of manual restraint.** (a) Within five
310.22 working days of the emergency use of manual restraint, the license holder must complete
310.23 an internal review of each report of emergency use of manual restraint. The review must
310.24 include an evaluation of whether:

310.25 (1) the person's service and support strategies developed according to sections
310.26 245D.07 and 245D.071 need to be revised;

310.27 (2) related policies and procedures were followed;

310.28 (3) the policies and procedures were adequate;

310.29 (4) there is a need for additional staff training;

310.30 (5) the reported event is similar to past events with the persons, staff, or the services
310.31 involved; and

310.32 (6) there is a need for corrective action by the license holder to protect the health
310.33 and safety of persons.

310.34 (b) Based on the results of the internal review, the license holder must develop,
310.35 document, and implement a corrective action plan for the program designed to correct
310.36 current lapses and prevent future lapses in performance by individuals or the license

311.1 holder, if any. The corrective action plan, if any, must be implemented within 30 days of
311.2 the internal review being completed.

311.3 Subd. 9. **Expanded support team review.** (a) Within five working days after the
311.4 completion of the internal review required in subdivision 8, the license holder must consult
311.5 with the expanded support team following the emergency use of manual restraint to:

311.6 (1) discuss the incident reported in subdivision 7, to define the antecedent or event
311.7 that gave rise to the behavior resulting in the manual restraint and identify the perceived
311.8 function the behavior served; and

311.9 (2) determine whether the person's coordinated service and support plan addendum
311.10 needs to be revised according to sections 245D.07 and 245D.071 to positively and
311.11 effectively help the person maintain stability and to reduce or eliminate future occurrences
311.12 requiring emergency use of manual restraint.

311.13 Subd. 10. **Emergency use of manual restraints policy and procedures.** The
311.14 license holder must develop, document, and implement a policy and procedures that
311.15 promote service recipient rights and protect health and safety during the emergency use of
311.16 manual restraints. The policy and procedures must comply with the requirements of this
311.17 section and must specify the following:

311.18 (1) a description of the positive support strategies and techniques staff must use to
311.19 attempt to de-escalate a person's behavior before it poses an imminent risk of physical
311.20 harm to self or others;

311.21 (2) a description of the types of manual restraints the license holder allows staff to
311.22 use on an emergency basis, if any. If the license holder will not allow the emergency use
311.23 of manual restraint, the policy and procedure must identify the alternative measures the
311.24 license holder will require staff to use when a person's conduct poses an imminent risk of
311.25 physical harm to self or others and less restrictive strategies would not achieve safety;

311.26 (3) instructions for safe and correct implementation of the allowed manual restraint
311.27 procedures;

311.28 (4) the training that staff must complete and the timelines for completion, before they
311.29 may implement an emergency use of manual restraint. In addition to the training on this
311.30 policy and procedure and the orientation and annual training required in section 245D.09,
311.31 subdivision 4, the training for emergency use of manual restraint must incorporate the
311.32 following subjects:

311.33 (i) alternatives to manual restraint procedures, including techniques to identify
311.34 events and environmental factors that may escalate conduct that poses an imminent risk of
311.35 physical harm to self or others;

312.1 (ii) de-escalation methods, positive support strategies, and how to avoid power
312.2 struggles;
312.3 (iii) simulated experiences of administering and receiving manual restraint
312.4 procedures allowed by the license holder on an emergency basis;
312.5 (iv) how to properly identify thresholds for implementing and ceasing restrictive
312.6 procedures;
312.7 (v) how to recognize, monitor, and respond to the person's physical signs of distress,
312.8 including positional asphyxia;
312.9 (vi) the physiological and psychological impact on the person and the staff when
312.10 restrictive procedures are used;
312.11 (vii) the communicative intent of behaviors; and
312.12 (viii) relationship building;
312.13 (5) the procedures and forms to be used to monitor the emergency use of manual
312.14 restraints, including what must be monitored and the frequency of monitoring per
312.15 each incident of emergency use of manual restraint, and the person or position who is
312.16 responsible for monitoring the use;
312.17 (6) the instructions, forms, and timelines required for completing and submitting an
312.18 incident report by the person or persons who implemented the manual restraint; and
312.19 (7) the procedures and timelines for conducting the internal review and the expanded
312.20 support team review, and the person or position responsible for completing the reviews and
312.21 who is responsible for ensuring that corrective action is taken or the person's coordinated
312.22 service and support plan addendum is revised, when determined necessary.

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

312.24 Sec. 24. Minnesota Statutes 2012, section 245D.07, is amended to read:

312.25 **245D.07 SERVICE ~~NEEDS~~ PLANNING AND DELIVERY.**

312.26 Subdivision 1. **Provision of services.** The license holder must provide services as
312.27 ~~specified~~ assigned in the coordinated service and support plan ~~and assigned to the license~~
312.28 ~~holder~~. The provision of services must comply with the requirements of this chapter and
312.29 the federal waiver plans.

312.30 Subd. 1a. **Person-centered planning and service delivery.** (a) The license holder
312.31 must provide services in response to the person's identified needs, interests, preferences,
312.32 and desired outcomes as specified in the coordinated service and support plan, the
312.33 coordinated service and support plan addendum, and in compliance with the requirements

313.1 of this chapter. License holders providing intensive support services must also provide
313.2 outcome-based services according to the requirements in section 245D.071.
313.3 (b) Services must be provided in a manner that supports the person's preferences,
313.4 daily needs, and activities and accomplishment of the person's personal goals and service
313.5 outcomes, consistent with the principles of:
313.6 (1) person-centered service planning and delivery that:
313.7 (i) identifies and supports what is important to the person as well as what is
313.8 important for the person, including preferences for when, how, and by whom direct
313.9 support service is provided;
313.10 (ii) uses that information to identify outcomes the person desires; and
313.11 (iii) respects each person's history, dignity, and cultural background;
313.12 (2) self-determination that supports and provides:
313.13 (i) opportunities for the development and exercise of functional and age-appropriate
313.14 skills, decision making and choice, personal advocacy, and communication; and
313.15 (ii) the affirmation and protection of each person's civil and legal rights;
313.16 (3) providing the most integrated setting and inclusive service delivery that supports,
313.17 promotes, and allows:
313.18 (i) inclusion and participation in the person's community as desired by the person
313.19 in a manner that enables the person to interact with nondisabled persons to the fullest
313.20 extent possible and supports the person in developing and maintaining a role as a valued
313.21 community member;
313.22 (ii) opportunities for self-sufficiency as well as developing and maintaining social
313.23 relationships and natural supports; and
313.24 (iii) a balance between risk and opportunity, meaning the least restrictive supports or
313.25 interventions necessary are provided in the most integrated settings in the most inclusive
313.26 manner possible to support the person to engage in activities of the person's own choosing
313.27 that may otherwise present a risk to the person's health, safety, or rights.
313.28 Subd. 2. **Service planning requirements for basic support services.** (a) License
313.29 holders providing basic support services must meet the requirements of this subdivision.
313.30 (b) Within 15 days of service initiation the license holder must complete a
313.31 preliminary coordinated service and support plan addendum based on the coordinated
313.32 service and support plan.
313.33 (c) Within 60 days of service initiation the license holder must review and revise as
313.34 needed the preliminary coordinated service and support plan addendum to document the
313.35 services that will be provided including how, when, and by whom services will be provided,
313.36 and the person responsible for overseeing the delivery and coordination of services.

314.1 (d) The license holder must participate in service planning and support team
314.2 meetings ~~related to~~ for the person following stated timelines established in the person's
314.3 coordinated service and support plan or as requested by ~~the support team,~~ the person~~,~~ or
314.4 the person's legal representative, the support team or the expanded support team.

314.5 Subd. 3. **Reports.** The license holder must provide written reports regarding the
314.6 person's progress or status as requested by the person, the person's legal representative, the
314.7 case manager, or the team.

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

314.9 Sec. 25. **[245D.071] SERVICE PLANNING AND DELIVERY; INTENSIVE**
314.10 **SUPPORT SERVICES.**

314.11 Subdivision 1. **Requirements for intensive support services.** A license holder
314.12 providing intensive support services identified in section 245D.03, subdivision 1,
314.13 paragraph (c), must comply with the requirements in section 245D.07, subdivisions 1
314.14 and 3, and this section.

314.15 Subd. 2. **Abuse prevention.** Prior to or upon initiating services, the license holder
314.16 must develop, document, and implement an abuse prevention plan according to section
314.17 245A.65, subdivision 2.

314.18 Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service
314.19 initiation the license holder must complete a preliminary coordinated service and support
314.20 plan addendum based on the coordinated service and support plan.

314.21 (b) Within 45 days of service initiation the license holder must meet with the person,
314.22 the person's legal representative, the case manager, and other members of the support team
314.23 or expanded support team to assess and determine the following based on the person's
314.24 coordinated service and support plan and the requirements in subdivision 4 and section
314.25 245D.07, subdivision 1a:

314.26 (1) the scope of the services to be provided to support the person's daily needs
314.27 and activities;

314.28 (2) the person's desired outcomes and the supports necessary to accomplish the
314.29 person's desired outcomes;

314.30 (3) the person's preferences for how services and supports are provided;

314.31 (4) whether the current service setting is the most integrated setting available and
314.32 appropriate for the person; and

314.33 (5) how services must be coordinated across other providers licensed under this
314.34 chapter serving the same person to ensure continuity of care for the person.

315.1 (c) Within the scope of services, the license holder must, at a minimum, assess
315.2 the following areas:
315.3 (1) the person's ability to self-manage health and medical needs to maintain or
315.4 improve physical, mental, and emotional well-being, including, when applicable, allergies,
315.5 seizures, choking, special dietary needs, chronic medical conditions, self-administration
315.6 of medication or treatment orders, preventative screening, and medical and dental
315.7 appointments;
315.8 (2) the person's ability to self-manage personal safety to avoid injury or accident in
315.9 the service setting, including, when applicable, risk of falling, mobility, regulating water
315.10 temperature, community survival skills, water safety skills, and sensory disabilities; and
315.11 (3) the person's ability to self-manage symptoms or behavior that may otherwise
315.12 result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to
315.13 (7), suspension or termination of services by the license holder, or other symptoms
315.14 or behaviors that may jeopardize the health and safety of the person or others. The
315.15 assessments must produce information about the person that is descriptive of the person's
315.16 overall strengths, functional skills and abilities, and behaviors or symptoms.
315.17 Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the
315.18 45-day meeting, the license holder must develop and document the service outcomes and
315.19 supports based on the assessments completed under subdivision 3 and the requirements
315.20 in section 245D.07, subdivision 1a. The outcomes and supports must be included in the
315.21 coordinated service and support plan addendum.
315.22 (b) The license holder must document the supports and methods to be implemented
315.23 to support the accomplishment of outcomes related to acquiring, retaining, or improving
315.24 skills. The documentation must include:
315.25 (1) the methods or actions that will be used to support the person and to accomplish
315.26 the service outcomes, including information about:
315.27 (i) any changes or modifications to the physical and social environments necessary
315.28 when the service supports are provided;
315.29 (ii) any equipment and materials required; and
315.30 (iii) techniques that are consistent with the person's communication mode and
315.31 learning style;
315.32 (2) the measurable and observable criteria for identifying when the desired outcome
315.33 has been achieved and how data will be collected;
315.34 (3) the projected starting date for implementing the supports and methods and
315.35 the date by which progress towards accomplishing the outcomes will be reviewed and
315.36 evaluated; and

316.1 (4) the names of the staff or position responsible for implementing the supports
316.2 and methods.
316.3 (c) Within 20 working days of the 45-day meeting, the license holder must obtain
316.4 dated signatures from the person or the person's legal representative and case manager
316.5 to document completion and approval of the assessment and coordinated service and
316.6 support plan addendum.
316.7 Subd. 5. **Progress reviews.** (a) The license holder must give the person or the
316.8 person's legal representative and case manager an opportunity to participate in the ongoing
316.9 review and development of the methods used to support the person and accomplish
316.10 outcomes identified in subdivisions 3 and 4. The license holder, in coordination with
316.11 the person's support team or expanded support team, must meet with the person, the
316.12 person's legal representative, and the case manager, and participate in progress review
316.13 meetings following stated timelines established in the person's coordinated service and
316.14 support plan or coordinated service and support plan addendum or within 30 days of a
316.15 written request by the person, the person's legal representative, or the case manager,
316.16 at a minimum of once per year.
316.17 (b) The license holder must summarize the person's progress toward achieving the
316.18 identified outcomes and make recommendations and identify the rationale for changing,
316.19 continuing, or discontinuing implementation of supports and methods identified in
316.20 subdivision 4 in a written report sent to the person or the person's legal representative
316.21 and case manager five working days prior to the review meeting, unless the person, the
316.22 person's legal representative, or the case manager request to receive the report at the
316.23 time of the meeting.
316.24 (c) Within ten working days of the progress review meeting, the license holder
316.25 must obtain dated signatures from the person or the person's legal representative and
316.26 the case manager to document approval of any changes to the coordinated service and
316.27 support plan addendum.

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

316.29 Sec. 26. **[245D.081] PROGRAM COORDINATION, EVALUATION, AND**
316.30 **OVERSIGHT.**

316.31 Subdivision 1. **Program coordination and evaluation.** (a) The license holder
316.32 is responsible for:
316.33 (1) coordination of service delivery and evaluation for each person served by the
316.34 program as identified in subdivision 2; and

317.1 (2) program management and oversight that includes evaluation of the program
317.2 quality and program improvement for services provided by the license holder as identified
317.3 in subdivision 3.

317.4 (b) The same person may perform the functions in paragraph (a) if the work and
317.5 education qualifications are met in subdivisions 2 and 3.

317.6 Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery
317.7 and evaluation of services provided by the license holder must be coordinated by a
317.8 designated staff person. The designated coordinator must provide supervision, support,
317.9 and evaluation of activities that include:

317.10 (1) oversight of the license holder's responsibilities assigned in the person's
317.11 coordinated service and support plan and the coordinated service and support plan
317.12 addendum;

317.13 (2) taking the action necessary to facilitate the accomplishment of the outcomes
317.14 according to the requirements in section 245D.07;

317.15 (3) instruction and assistance to direct support staff implementing the coordinated
317.16 service and support plan and the service outcomes, including direct observation of service
317.17 delivery sufficient to assess staff competency; and

317.18 (4) evaluation of the effectiveness of service delivery, methodologies, and progress on
317.19 the person's outcomes based on the measurable and observable criteria for identifying when
317.20 the desired outcome has been achieved according to the requirements in section 245D.07.

317.21 (b) The license holder must ensure that the designated coordinator is competent to
317.22 perform the required duties identified in paragraph (a) through education and training in
317.23 human services and disability-related fields, and work experience in providing direct care
317.24 services and supports to persons with disabilities. The designated coordinator must have
317.25 the skills and ability necessary to develop effective plans and to design and use data
317.26 systems to measure effectiveness of services and supports. The license holder must verify
317.27 and document competence according to the requirements in section 245D.09, subdivision
317.28 3. The designated coordinator must minimally have:

317.29 (1) a baccalaureate degree in a field related to human services, and one year of
317.30 full-time work experience providing direct care services to persons with disabilities or
317.31 persons age 65 and older;

317.32 (2) an associate degree in a field related to human services, and two years of
317.33 full-time work experience providing direct care services to persons with disabilities or
317.34 persons age 65 and older;

318.1 (3) a diploma in a field related to human services from an accredited postsecondary
318.2 institution and three years of full-time work experience providing direct care services to
318.3 persons with disabilities or persons age 65 and older; or
318.4 (4) a minimum of 50 hours of education and training related to human services
318.5 and disabilities, and
318.6 four years of full-time work experience providing direct care services to persons
318.7 with disabilities or persons age 65 and older under the supervision of a staff person who
318.8 meets the qualifications identified in clauses (1) to (3).
318.9 Subd. 3. **Program management and oversight.** (a) The license holder must
318.10 designate a managerial staff person or persons to provide program management and
318.11 oversight of the services provided by the license holder. The designated manager is
318.12 responsible for the following:
318.13 (1) maintaining a current understanding of the licensing requirements sufficient to
318.14 ensure compliance throughout the program as identified in section 245A.04, subdivision
318.15 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21,
318.16 paragraph (b);
318.17 (2) ensuring the duties of the designated coordinator are fulfilled according to the
318.18 requirements in subdivision 2;
318.19 (3) ensuring the program implements corrective action identified as necessary
318.20 by the program following review of incident and emergency reports according to the
318.21 requirements in section 245D.11, subdivision 2, clause (7). An internal review of
318.22 incident reports of alleged or suspected maltreatment must be conducted according to the
318.23 requirements in section 245A.65, subdivision 1, paragraph (b);
318.24 (4) evaluation of satisfaction of persons served by the program, the person's legal
318.25 representative, if any, and the case manager, with the service delivery and progress
318.26 towards accomplishing outcomes identified in sections 245D.07 and 245D.071, and
318.27 ensuring and protecting each person's rights as identified in section 245D.04;
318.28 (5) ensuring staff competency requirements are met according to the requirements in
318.29 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
318.30 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;
318.31 (6) ensuring corrective action is taken when ordered by the commissioner and that
318.32 the terms and condition of the license and any variances are met; and
318.33 (7) evaluating the information identified in clauses (1) to (6) to develop, document,
318.34 and implement ongoing program improvements.
318.35 (b) The designated manager must be competent to perform the duties as required and
318.36 must minimally meet the education and training requirements identified in subdivision

319.1 2, paragraph (b), and have a minimum of three years of supervisory level experience in
319.2 a program providing direct support services to persons with disabilities or persons age
319.3 65 and older.

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

319.5 Sec. 27. Minnesota Statutes 2012, section 245D.09, is amended to read:

319.6 **245D.09 STAFFING STANDARDS.**

319.7 Subdivision 1. **Staffing requirements.** The license holder must provide the level of
319.8 direct service support staff sufficient supervision, assistance, and training necessary:
319.9 (1) to ensure the health, safety, and protection of rights of each person; and
319.10 (2) to be able to implement the responsibilities assigned to the license holder in each
319.11 person's coordinated service and support plan or identified in the coordinated service and
319.12 support plan addendum, according to the requirements of this chapter.

319.13 Subd. 2. **Supervision of staff having direct contact.** Except for a license holder
319.14 who is the sole direct service support staff, the license holder must provide adequate
319.15 supervision of staff providing direct service support to ensure the health, safety, and
319.16 protection of rights of each person and implementation of the responsibilities assigned to
319.17 the license holder in each person's service plan coordinated service and support plan or
319.18 coordinated service and support plan addendum.

319.19 Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing
319.20 direct support, or staff who have responsibilities related to supervising or managing the
319.21 provision of direct support service, is competent as demonstrated through skills and
319.22 knowledge training, experience, and education to meet the person's needs and additional
319.23 requirements as written in the coordinated service and support plan or coordinated
319.24 service and support plan addendum, or when otherwise required by the case manager or
319.25 the federal waiver plan. The license holder must verify and maintain evidence of staff
319.26 competency, including documentation of:
319.27 (1) education and experience qualifications relevant to the job responsibilities
319.28 assigned to the staff and the needs of the general population of persons served by the
319.29 program, including a valid degree and transcript, or a current license, registration, or
319.30 certification, when a degree or licensure, registration, or certification is required by this
319.31 chapter or in the coordinated service and support plan or coordinated service and support
319.32 plan addendum;
319.33 (2) completion of required demonstrated competency in the orientation and training
319.34 areas required under this chapter, including and when applicable, completion of continuing

320.1 education required to maintain professional licensure, registration, or certification
320.2 requirements. Competency in these areas is determined by the license holder through
320.3 knowledge testing and observed skill assessment conducted by the trainer or instructor; and
320.4 (3) except for a license holder who is the sole direct ~~service~~ support staff, periodic
320.5 performance evaluations completed by the license holder of the direct ~~service~~ support staff
320.6 person's ability to perform the job functions based on direct observation.
320.7 (b) Staff under 18 years of age may not perform overnight duties or administer
320.8 medication.
320.9 Subd. 4. **Orientation to program requirements.** ~~(a)~~ Except for a license holder
320.10 who does not supervise any direct ~~service~~ support staff, within ~~90 days of hiring direct~~
320.11 ~~service staff~~ 60 days of hire, unless stated otherwise, the license holder must provide
320.12 and ensure completion of orientation for direct support staff that combines supervised
320.13 on-the-job training with review of and instruction ~~on~~ in the following areas:
320.14 (1) the job description and how to complete specific job functions, including:
320.15 (i) responding to and reporting incidents as required under section 245D.06,
320.16 subdivision 1; and
320.17 (ii) following safety practices established by the license holder and as required in
320.18 section 245D.06, subdivision 2;
320.19 (2) the license holder's current policies and procedures required under this chapter,
320.20 including their location and access, and staff responsibilities related to implementation
320.21 of those policies and procedures;
320.22 (3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the
320.23 federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff
320.24 responsibilities related to complying with data privacy practices;
320.25 (4) the service recipient rights ~~under section 245D.04~~, and staff responsibilities
320.26 related to ensuring the exercise and protection of those rights according to the requirements
320.27 in section 245D.04;
320.28 (5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment
320.29 reporting and service planning for children and vulnerable adults, and staff responsibilities
320.30 related to protecting persons from maltreatment and reporting maltreatment. This
320.31 orientation must be provided within 72 hours of first providing direct contact services and
320.32 annually thereafter according to section 245A.65, subdivision 3;
320.33 (6) ~~what constitutes use of restraints, seclusion, and psychotropic medications,~~
320.34 ~~and staff responsibilities related to the prohibitions of their use~~ the principles of
320.35 person-centered service planning and delivery as identified in section 245D.07, subdivision
320.36 1a, and how they apply to direct support service provided by the staff person; and

321.1 (7) other topics as determined necessary in the person's coordinated service and
321.2 support plan by the case manager or other areas identified by the license holder.
321.3 ~~(b) License holders who provide direct service themselves must complete the~~
321.4 ~~orientation required in paragraph (a), clauses (3) to (7).~~
321.5 Subd. 4a. **Orientation to individual service recipient needs.** ~~(c)~~ (a) Before
321.6 ~~providing~~ having unsupervised direct ~~service to~~ contact with a person served by the
321.7 program, or for whom the staff person has not previously provided direct ~~service~~ support,
321.8 or any time the plans or procedures identified in ~~clauses (1) and (2)~~ paragraphs (b) to
321.9 (e) are revised, the staff person must review and receive instruction on the ~~following~~
321.10 ~~as it relates~~ requirements in paragraphs (b) to (e) as they relate to the staff person's job
321.11 functions for that person~~:~~.
321.12 ~~(1)~~ (b) The staff person must review and receive instruction on the person's
321.13 coordinated service and support plan or coordinated service and support plan addendum as
321.14 it relates to the responsibilities assigned to the license holder, and when applicable, the
321.15 person's individual abuse prevention plan ~~according to section 245A.65~~, to achieve and
321.16 demonstrate an understanding of the person as a unique individual, and how to implement
321.17 those plans~~; and~~.
321.18 ~~(2)~~ (c) The staff person must review and receive instruction on medication
321.19 administration procedures established for the person when medication administration is
321.20 assigned to the license holder according to section 245D.05, subdivision 1, paragraph
321.21 (b). Unlicensed staff may administer medications only after successful completion of a
321.22 medication administration training, from a training curriculum developed by a registered
321.23 nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse
321.24 practitioner, physician's assistant, or physician ~~incorporating~~. The training curriculum
321.25 must incorporate an observed skill assessment conducted by the trainer to ensure staff
321.26 demonstrate the ability to safely and correctly follow medication procedures.
321.27 Medication administration must be taught by a registered nurse, clinical nurse
321.28 specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of
321.29 service initiation or any time thereafter, the person has or develops a health care condition
321.30 that affects the service options available to the person because the condition requires:
321.31 ~~(i)~~ (1) specialized or intensive medical or nursing supervision; and
321.32 ~~(ii)~~ (2) nonmedical service providers to adapt their services to accommodate the
321.33 health and safety needs of the person~~; and~~.
321.34 ~~(iii) necessary training in order to meet the health service needs of the person as~~
321.35 ~~determined by the person's physician.~~

322.1 (d) The staff person must review and receive instruction on the safe and correct
322.2 operation of medical equipment used by the person to sustain life, including but not
322.3 limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided
322.4 by a licensed health care professional or a manufacturer's representative and incorporate
322.5 an observed skill assessment to ensure staff demonstrate the ability to safely and correctly
322.6 operate the equipment according to the treatment orders and the manufacturer's instructions.

322.7 (e) The staff person must review and receive instruction on what constitutes use of
322.8 restraints, time out, and seclusion, including chemical restraint, and staff responsibilities
322.9 related to the prohibitions of their use according to the requirements in section 245D.06,
322.10 subdivision 5, why such procedures are not effective for reducing or eliminating symptoms
322.11 or undesired behavior and why they are not safe, and the safe and correct use of manual
322.12 restraint on an emergency basis according to the requirements in section 245D.061.

322.13 (f) In the event of an emergency service initiation, the license holder must ensure
322.14 the training required in this subdivision occurs within 72 hours of the direct support staff
322.15 person first having unsupervised contact with the person receiving services. The license
322.16 holder must document the reason for the unplanned or emergency service initiation and
322.17 maintain the documentation in the person's service recipient record.

322.18 (g) License holders who provide direct support services themselves must complete
322.19 the orientation required in subdivision 4, clauses (3) to (7).

322.20 Subd. 5. **Annual training.** ~~(a)~~ A license holder must provide annual training to
322.21 direct ~~service~~ support staff on the topics identified in subdivision 4, ~~paragraph (a),~~ clauses
322.22 (3) to ~~(6)~~ (7). Training on relevant topics received from sources other than the license
322.23 holder may count toward training requirements.

322.24 ~~(b) A license holder providing behavioral programming, specialist services, personal~~
322.25 ~~support, 24-hour emergency assistance, night supervision, independent living skills,~~
322.26 ~~structured day, prevocational, or supported employment services must provide a minimum~~
322.27 ~~of eight hours of annual training to direct service staff that addresses:~~

322.28 ~~(1) topics related to the general health, safety, and service needs of the population~~
322.29 ~~served by the license holder; and~~

322.30 ~~(2) other areas identified by the license holder or in the person's current service plan.~~

322.31 ~~Training on relevant topics received from sources other than the license holder~~
322.32 ~~may count toward training requirements.~~

322.33 ~~(c) When the license holder is the owner, lessor, or tenant of the service site and~~
322.34 ~~whenever a person receiving services is present at the site, the license holder must have~~
322.35 ~~a staff person available on site who is trained in basic first aid and, when required in a~~
322.36 ~~person's service plan, cardiopulmonary resuscitation.~~

323.1 Subd. 5a. **Alternative sources of training.** Orientation or training received by the
323.2 staff person from sources other than the license holder in the same subjects as identified
323.3 in subdivision 4 may count toward the orientation and annual training requirements if
323.4 received in the 12-month period before the staff person's date of hire. The license holder
323.5 must maintain documentation of the training received from other sources and of each staff
323.6 person's competency in the required area according to the requirements in subdivision 3.

323.7 Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a
323.8 subcontractor or temporary staff to perform services licensed under this chapter on the
323.9 license holder's behalf, the license holder must ensure that the subcontractor or temporary
323.10 staff meets and maintains compliance with all requirements under this chapter that apply
323.11 to the services to be provided, including training, orientation, and supervision necessary
323.12 to fulfill their responsibilities. The license holder must ensure that a background study
323.13 has been completed according to the requirements in sections 245C.03, subdivision 1,
323.14 and 245C.04. Subcontractors and temporary staff hired by the license holder must meet
323.15 the Minnesota licensing requirements applicable to the disciplines in which they are
323.16 providing services. The license holder must maintain documentation that the applicable
323.17 requirements have been met.

323.18 Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide
323.19 direct support services to persons served by the program receive the training, orientation,
323.20 and supervision necessary to fulfill their responsibilities. The license holder must ensure
323.21 that a background study has been completed according to the requirements in sections
323.22 245C.03, subdivision 1, and 245C.04. The license holder must maintain documentation
323.23 that the applicable requirements have been met.

323.24 Subd. 8. **Staff orientation and training plan.** The license holder must develop
323.25 a staff orientation and training plan documenting when and how compliance with
323.26 subdivisions 4, 4a, and 5 will be met.

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

323.28 Sec. 28. **[245D.091] INTERVENTION SERVICES.**

323.29 Subdivision 1. **Licensure requirements.** An individual meeting the staff
323.30 qualification requirements of this section who is an employee of a program licensed
323.31 according to this chapter and providing behavioral support services, specialist services,
323.32 or crisis respite services is not required to hold a separate license under this chapter.
323.33 An individual meeting the staff qualifications of this section who is not providing these
323.34 services as an employee of a program licensed according to this chapter must obtain a
323.35 license according to this chapter.

324.1 Subd. 2. **Behavior professional qualifications.** A behavior professional, as defined
324.2 in the brain injury and community alternatives for disabled individuals waiver plans or
324.3 successor plans, must have competencies in areas related to:
324.4 (1) ethical considerations;
324.5 (2) functional assessment;
324.6 (3) functional analysis;
324.7 (4) measurement of behavior and interpretation of data;
324.8 (5) selecting intervention outcomes and strategies;
324.9 (6) behavior reduction and elimination strategies that promote least restrictive
324.10 approved alternatives;
324.11 (7) data collection;
324.12 (8) staff and caregiver training;
324.13 (9) support plan monitoring;
324.14 (10) co-occurring mental disorders or neuro-cognitive disorder;
324.15 (11) demonstrated expertise with populations being served; and
324.16 (12) must be a:
324.17 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the
324.18 Board of Psychology competencies in the above identified areas;
324.19 (ii) clinical social worker licensed as an independent clinical social worker under
324.20 chapter 148D, or a person with a master's degree in social work from an accredited college
324.21 or university, with at least 4,000 hours of post-master's supervised experience in the
324.22 delivery of clinical services in the areas identified in clauses (1) to (11);
324.23 (iii) physician licensed under chapter 147 and certified by the American Board
324.24 of Psychiatry and Neurology or eligible for board certification in psychiatry with
324.25 competencies in the areas identified in clauses (1) to (11);
324.26 (iv) licensed professional clinical counselor licensed under sections 148B.29 to
324.27 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery
324.28 of clinical services who has demonstrated competencies in the areas identified in clauses
324.29 (1) to (11);
324.30 (v) person with a master's degree from an accredited college or university in one
324.31 of the behavioral sciences or related fields, with at least 4,000 hours of post-master's
324.32 supervised experience in the delivery of clinical services with demonstrated competencies
324.33 in the areas identified in clauses (1) to (11); or
324.34 (vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is
324.35 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
324.36 mental health nursing by a national nurse certification organization, or who has a master's

325.1 degree in nursing or one of the behavioral sciences or related fields from an accredited
325.2 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
325.3 experience in the delivery of clinical services.

325.4 Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst, as defined in
325.5 the brain injury and community alternatives for disabled individuals waiver plans or
325.6 successor plans, must:

325.7 (1) have obtained a baccalaureate degree, master's degree, or a PhD in a social
325.8 services discipline; or

325.9 (2) meet the qualifications of a mental health practitioner as defined in section
325.10 245.462, subdivision 17.

325.11 (b) In addition, a behavior analyst must:

325.12 (1) have four years of supervised experience working with individuals who exhibit
325.13 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder;

325.14 (2) have received ten hours of instruction in functional assessment and functional
325.15 analysis;

325.16 (3) have received 20 hours of instruction in the understanding of the function of
325.17 behavior;

325.18 (4) have received ten hours of instruction on design of positive practices behavior
325.19 support strategies;

325.20 (5) have received 20 hours of instruction on the use of behavior reduction approved
325.21 strategies used only in combination with behavior positive practices strategies;

325.22 (6) be determined by a behavior professional to have the training and prerequisite
325.23 skills required to provide positive practice strategies as well as behavior reduction
325.24 approved and permitted intervention to the person who receives behavioral support; and

325.25 (7) be under the direct supervision of a behavior professional.

325.26 Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist, as defined
325.27 in the brain injury and community alternatives for disabled individuals waiver plans or
325.28 successor plans, must meet the following qualifications:

325.29 (1) have an associate's degree in a social services discipline; or

325.30 (2) have two years of supervised experience working with individuals who exhibit
325.31 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder.

325.32 (b) In addition, a behavior specialist must:

325.33 (1) have received a minimum of four hours of training in functional assessment;

325.34 (2) have received 20 hours of instruction in the understanding of the function of
325.35 behavior;

326.1 (3) have received ten hours of instruction on design of positive practices behavioral
326.2 support strategies;
326.3 (4) be determined by a behavior professional to have the training and prerequisite
326.4 skills required to provide positive practices strategies as well as behavior reduction
326.5 approved intervention to the person who receives behavioral support; and
326.6 (5) be under the direct supervision of a behavior professional.
326.7 Subd. 5. **Specialist services qualifications.** An individual providing specialist
326.8 services, as defined in the developmental disabilities waiver plan or successor plan, must
326.9 have:
326.10 (1) the specific experience and skills required of the specialist to meet the needs of
326.11 the person identified by the person's service planning team; and
326.12 (2) the qualifications of the specialist identified in the person's coordinated service
326.13 and support plan.

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

326.15 Sec. 29. **[245D.095] RECORD REQUIREMENTS.**
326.16 Subdivision 1. **Record-keeping systems.** The license holder must ensure that the
326.17 content and format of service recipient, personnel, and program records are uniform and
326.18 legible according to the requirements of this chapter.
326.19 Subd. 2. **Admission and discharge register.** The license holder must keep a written
326.20 or electronic register, listing in chronological order the dates and names of all persons
326.21 served by the program who have been admitted, discharged, or transferred, including
326.22 service terminations initiated by the license holder and deaths.
326.23 Subd. 3. **Service recipient record.** (a) The license holder must maintain a record of
326.24 current services provided to each person on the premises where the services are provided
326.25 or coordinated. When the services are provided in a licensed facility, the records must
326.26 be maintained at the facility, otherwise the records must be maintained at the license
326.27 holder's program office. The license holder must protect service recipient records against
326.28 loss, tampering, or unauthorized disclosure according to the requirements in sections
326.29 13.01 to 13.10 and 13.46.
326.30 (b) The license holder must maintain the following information for each person:
326.31 (1) an admission form signed by the person or the person's legal representative
326.32 that includes:
326.33 (i) identifying information, including the person's name, date of birth, address,
326.34 and telephone number; and

327.1 (ii) the name, address, and telephone number of the person's legal representative, if
327.2 any, and a primary emergency contact, the case manager, and family members or others as
327.3 identified by the person or case manager;
327.4 (2) service information, including service initiation information, verification of the
327.5 person's eligibility for services, documentation verifying that services have been provided
327.6 as identified in the coordinated service and support plan or coordinated service and support
327.7 plan addendum according to paragraph (a), and date of admission or readmission;
327.8 (3) health information, including medical history, special dietary needs, and
327.9 allergies, and when the license holder is assigned responsibility for meeting the person's
327.10 health service needs according to section 245D.05:
327.11 (i) current orders for medication, treatments, or medical equipment and a signed
327.12 authorization from the person or the person's legal representative to administer or assist in
327.13 administering the medication or treatments, if applicable;
327.14 (ii) a signed statement authorizing the license holder to act in a medical emergency
327.15 when the person's legal representative, if any, cannot be reached or is delayed in arriving;
327.16 (iii) medication administration procedures;
327.17 (iv) a medication administration record documenting the implementation of the
327.18 medication administration procedures, the medication administration record reviews, and
327.19 including any agreements for administration of injectable medications by the license
327.20 holder according to the requirements in section 245D.05; and
327.21 (v) a medical appointment schedule when the license holder is assigned
327.22 responsibility for assisting with medical appointments;
327.23 (4) the person's current coordinated service and support plan or that portion of the
327.24 plan assigned to the license holder;
327.25 (5) copies of the individual abuse prevention plan and assessments as required under
327.26 section 245D.071, subdivisions 2 and 3;
327.27 (6) a record of other service providers serving the person when the person's
327.28 coordinated service and support plan or coordinated service and support plan addendum
327.29 identifies the need for coordination between the service providers, that includes a contact
327.30 person and telephone numbers, services being provided, and names of staff responsible for
327.31 coordination;
327.32 (7) documentation of orientation to service recipient rights according to section
327.33 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to
327.34 section 245A.65, subdivision 1, paragraph (c);
327.35 (8) copies of authorizations to handle a person's funds, according to section 245D.06,
327.36 subdivision 4, paragraph (a);

328.1 (9) documentation of complaints received and grievance resolution;
328.2 (10) incident reports involving the person, required under section 245D.06,
328.3 subdivision 1;
328.4 (11) copies of written reports regarding the person's status when requested according
328.5 to section 245D.07, subdivision 3, progress review reports as required under section
328.6 245D.071, subdivision 5, progress or daily log notes that are recorded by the program,
328.7 and reports received from other agencies involved in providing services or care to the
328.8 person; and
328.9 (12) discharge summary, including service termination notice and related
328.10 documentation, when applicable.
328.11 Subd. 4. **Access to service recipient records.** The license holder must ensure that
328.12 the following people have access to the information in subdivision 1 in accordance with
328.13 applicable state and federal law, regulation, or rule:
328.14 (1) the person, the person's legal representative, and anyone properly authorized
328.15 by the person;
328.16 (2) the person's case manager;
328.17 (3) staff providing services to the person unless the information is not relevant to
328.18 carrying out the coordinated service and support plan or coordinated service and support
328.19 plan addendum; and
328.20 (4) the county child or adult foster care licensor, when services are also licensed as
328.21 child or adult foster care.
328.22 Subd. 5. **Personnel records.** (a) The license holder must maintain a personnel
328.23 record of each employee to document and verify staff qualifications, orientation, and
328.24 training. The personnel record must include:
328.25 (1) the employee's date of hire, completed application, an acknowledgement signed
328.26 by the employee that job duties were reviewed with the employee and the employee
328.27 understands those duties, and documentation that the employee meets the position
328.28 requirements as determined by the license holder;
328.29 (2) documentation of staff qualifications, orientation, training, and performance
328.30 evaluations as required under section 245D.09, subdivisions 3 to 5, including the date
328.31 the training was completed, the number of hours per subject area, and the name of the
328.32 trainer or instructor; and
328.33 (3) a completed background study as required under chapter 245C.
328.34 (b) For employees hired after January 1, 2014, the license holder must maintain
328.35 documentation in the personnel record or elsewhere, sufficient to determine the date of the

329.1 employee's first supervised direct contact with a person served by the program, and the
329.2 date of first unsupervised direct contact with a person served by the program.

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

329.4 Sec. 30. Minnesota Statutes 2012, section 245D.10, is amended to read:

329.5 **245D.10 POLICIES AND PROCEDURES.**

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

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

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

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

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

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

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

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

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

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

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

330.1 (6) provides a written summary of the complaint and a notice of the complaint
330.2 resolution to the person and case manager that:
330.3 (i) identifies the nature of the complaint and the date it was received;
330.4 (ii) includes the results of the complaint review;
330.5 (iii) identifies the complaint resolution, including any corrective action; and
330.6 (7) requires that the complaint summary and resolution notice be maintained in the
330.7 service recipient record.
330.8 Subd. 3. **Service suspension and service termination.** (a) The license holder must
330.9 establish policies and procedures for temporary service suspension and service termination
330.10 that promote continuity of care and service coordination with the person and the case
330.11 manager and with other licensed caregivers, if any, who also provide support to the person.
330.12 (b) The policy must include the following requirements:
330.13 (1) the license holder must notify the person or the person's legal representative and
330.14 case manager in writing of the intended termination or temporary service suspension, and
330.15 the person's right to seek a temporary order staying the termination of service according to
330.16 the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);
330.17 (2) notice of the proposed termination of services, including those situations
330.18 that began with a temporary service suspension, must be given at least 60 days before
330.19 the proposed termination is to become effective when a license holder is providing
330.20 ~~independent living skills training, structured day, prevocational or supported employment~~
330.21 ~~services to the person~~ intensive supports and services identified in section 245D.03,
330.22 subdivision 1, paragraph (c), and 30 days prior to termination for all other services
330.23 licensed under this chapter;
330.24 (3) the license holder must provide information requested by the person or case
330.25 manager when services are temporarily suspended or upon notice of termination;
330.26 (4) prior to giving notice of service termination or temporary service suspension,
330.27 the license holder must document actions taken to minimize or eliminate the need for
330.28 service suspension or termination;
330.29 (5) during the temporary service suspension or service termination notice period,
330.30 the license holder will work with the appropriate county agency to develop reasonable
330.31 alternatives to protect the person and others;
330.32 (6) the license holder must maintain information about the service suspension or
330.33 termination, including the written termination notice, in the service recipient record; and
330.34 (7) the license holder must restrict temporary service suspension to situations in
330.35 which the person's ~~behavior causes immediate and serious danger to the health and safety~~

331.1 ~~of the person or others~~ conduct poses an imminent risk of physical harm to self or others
331.2 and less restrictive or positive support strategies would not achieve safety.
331.3 Subd. 4. **Availability of current written policies and procedures.** (a) The license
331.4 holder must review and update, as needed, the written policies and procedures required
331.5 under this chapter.
331.6 (b)(1) The license holder must inform the person and case manager of the policies
331.7 and procedures affecting a person's rights under section 245D.04, and provide copies of
331.8 those policies and procedures, within five working days of service initiation.
331.9 (2) If a license holder only provides basic services and supports, this includes the:
331.10 (i) grievance policy and procedure required under subdivision 2; and
331.11 (ii) service suspension and termination policy and procedure required under
331.12 subdivision 3.
331.13 (3) For all other license holders this includes the:
331.14 (i) policies and procedures in clause (2);
331.15 (ii) emergency use of manual restraints policy and procedure required under
331.16 subdivision 3a; and
331.17 (iii) data privacy requirements under section 245D.11, subdivision 3.
331.18 (c) The license holder must provide a written notice at least 30 days before
331.19 implementing any ~~revised policies and procedures~~ procedural revisions to policies
331.20 affecting a person's service-related or protection-related rights under section 245D.04 and
331.21 maltreatment reporting policies and procedures. The notice must explain the revision that
331.22 was made and include a copy of the revised policy and procedure. The license holder
331.23 must document the ~~reason~~ reasonable cause for not providing the notice at least 30 days
331.24 before implementing the revisions.
331.25 (d) Before implementing revisions to required policies and procedures, the license
331.26 holder must inform all employees of the revisions and provide training on implementation
331.27 of the revised policies and procedures.
331.28 (e) The license holder must annually notify all persons, or their legal representatives,
331.29 and case managers of any procedural revisions to policies required under this chapter,
331.30 other than those in paragraph (c). Upon request, the license holder must provide the
331.31 person, or the person's legal representative, and case manager with copies of the revised
331.32 policies and procedures.

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

331.34 Sec. 31. **[245D.11] POLICIES AND PROCEDURES; INTENSIVE SUPPORT**
331.35 **SERVICES.**

332.1 Subdivision 1. **Policy and procedure requirements.** A license holder providing
332.2 intensive support services as identified in section 245D.03, subdivision 1, paragraph (c),
332.3 must establish, enforce, and maintain policies and procedures as required in this section.

332.4 Subd. 2. **Health and safety.** The license holder must establish policies and
332.5 procedures that promote health and safety by ensuring:

332.6 (1) use of universal precautions and sanitary practices in compliance with section
332.7 245D.06, subdivision 2, clause (5);

332.8 (2) if the license holder operates a residential program, health service coordination
332.9 and care according to the requirements in section 245D.05, subdivision 1;

332.10 (3) safe medication assistance and administration according to the requirements
332.11 in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
332.12 consultation with a registered nurse, nurse practitioner, physician's assistant, or medical
332.13 doctor and require completion of medication administration training according to the
332.14 requirements in section 245D.09, subdivision 4a, paragraph (c). Medication assistance
332.15 and administration includes, but is not limited to:

332.16 (i) providing medication-related services for a person;

332.17 (ii) medication setup;

332.18 (iii) medication administration;

332.19 (iv) medication storage and security;

332.20 (v) medication documentation and charting;

332.21 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
332.22 handling and administration;

332.23 (vii) coordination of medication refills;

332.24 (viii) handling changes to prescriptions and implementation of those changes;

332.25 (ix) communicating with the pharmacy; and

332.26 (x) coordination and communication with prescriber;

332.27 (4) safe transportation, when the license holder is responsible for transportation of
332.28 persons, with provisions for handling emergency situations according to the requirements
332.29 in section 245D.06, subdivision 2, clauses (2) to (4);

332.30 (5) a plan for ensuring the safety of persons served by the program in emergencies as
332.31 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
332.32 to the license holder. A license holder with a community residential setting or a day service
332.33 facility license must ensure the policy and procedures comply with the requirements in
332.34 section 245D.22, subdivision 4;

333.1 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision
333.2 11; and reporting all incidents required to be reported according to section 245D.06,
333.3 subdivision 1. The plan must:

333.4 (i) provide the contact information of a source of emergency medical care and
333.5 transportation; and

333.6 (ii) require staff to first call 911 when the staff believes a medical emergency may be
333.7 life threatening, or to call the mental health crisis intervention team when the person is
333.8 experiencing a mental health crisis; and

333.9 (7) a procedure for the review of incidents and emergencies to identify trends or
333.10 patterns, and corrective action if needed. The license holder must establish and maintain
333.11 a record-keeping system for the incident and emergency reports. Each incident and
333.12 emergency report file must contain a written summary of the incident. The license holder
333.13 must conduct a review of incident reports for identification of incident patterns, and
333.14 implementation of corrective action as necessary to reduce occurrences. Each incident
333.15 report must include:

333.16 (i) the name of the person or persons involved in the incident. It is not necessary
333.17 to identify all persons affected by or involved in an emergency unless the emergency
333.18 resulted in an incident;

333.19 (ii) the date, time, and location of the incident or emergency;

333.20 (iii) a description of the incident or emergency;

333.21 (iv) a description of the response to the incident or emergency and whether a person's
333.22 coordinated service and support plan addendum or program policies and procedures were
333.23 implemented as applicable;

333.24 (v) the name of the staff person or persons who responded to the incident or
333.25 emergency; and

333.26 (vi) the determination of whether corrective action is necessary based on the results
333.27 of the review.

333.28 Subd. 3. **Data privacy.** The license holder must establish policies and procedures that
333.29 promote service recipient rights by ensuring data privacy according to the requirements in:

333.30 (1) the Minnesota Government Data Practices Act, section 13.46, and all other
333.31 applicable Minnesota laws and rules in handling all data related to the services provided;
333.32 and

333.33 (2) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the
333.34 extent that the license holder performs a function or activity involving the use of protected
333.35 health information as defined under Code of Federal Regulations, title 45, section 164.501,
333.36 including, but not limited to, providing health care services; health care claims processing

334.1 or administration; data analysis, processing, or administration; utilization review; quality
334.2 assurance; billing; benefit management; practice management; repricing; or as otherwise
334.3 provided by Code of Federal Regulations, title 45, section 160.103. The license holder
334.4 must comply with the Health Insurance Portability and Accountability Act of 1996 and
334.5 its implementing regulations, Code of Federal Regulations, title 45, parts 160 to 164,
334.6 and all applicable requirements.

334.7 Subd. 4. **Admission criteria.** The license holder must establish policies and
334.8 procedures that promote continuity of care by ensuring that admission or service initiation
334.9 criteria:

334.10 (1) is consistent with the license holder's registration information identified in the
334.11 requirements in section 245D.031, subdivision 2, and with the service-related rights
334.12 identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

334.13 (2) identifies the criteria to be applied in determining whether the license holder
334.14 can develop services to meet the needs specified in the person's coordinated service and
334.15 support plan;

334.16 (3) requires a license holder providing services in a health care facility to comply
334.17 with the requirements in section 243.166, subdivision 4b, to provide notification to
334.18 residents when a registered predatory offender is admitted into the program or to a
334.19 potential admission when the facility was already serving a registered predatory offender.
334.20 For purposes of this clause, "health care facility" means a facility licensed by the
334.21 commissioner as a residential facility under chapter 245A to provide adult foster care or
334.22 residential services to persons with disabilities; and

334.23 (4) requires that when a person or the person's legal representative requests services
334.24 from the license holder, a refusal to admit the person must be based on an evaluation of
334.25 the person's assessed needs and the license holder's lack of capacity to meet the needs of
334.26 the person. The license holder must not refuse to admit a person based solely on the
334.27 type of residential services the person is receiving, or solely on the person's severity of
334.28 disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of
334.29 communication skills, physical disabilities, toilet habits, behavioral disorders, or past
334.30 failure to make progress. Documentation of the basis for refusal must be provided to the
334.31 person or the person's legal representative and case manager upon request.

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

334.33 Sec. 32. **[245D.21] FACILITY LICENSURE REQUIREMENTS AND**
334.34 **APPLICATION PROCESS.**

335.1 Subdivision 1. **Community residential settings and day service facilities.** For
335.2 purposes of this section, "facility" means both a community residential setting and day
335.3 service facility and the physical plant.

335.4 Subd. 2. **Inspections and code compliance.** (a) Physical plants must comply with
335.5 applicable state and local fire, health, building, and zoning codes.

335.6 (b)(1) The facility must be inspected by a fire marshal or their delegate within
335.7 12 months before initial licensure to verify that it meets the applicable occupancy
335.8 requirements as defined in the State Fire Code and that the facility complies with the fire
335.9 safety standards for that occupancy code contained in the State Fire Code.

335.10 (2) The fire marshal inspection of a community residential setting must verify the
335.11 residence is a dwelling unit within a residential occupancy as defined in section 9.117 of
335.12 the State Fire Code. A home safety checklist, approved by the commissioner, must be
335.13 completed for a community residential setting by the license holder and the commissioner
335.14 before the satellite license is reissued.

335.15 (3) The facility shall be inspected according to the facility capacity specified on the
335.16 initial application form.

335.17 (4) If the commissioner has reasonable cause to believe that a potentially hazardous
335.18 condition may be present or the licensed capacity is increased, the commissioner shall
335.19 request a subsequent inspection and written report by a fire marshal to verify the absence
335.20 of hazard.

335.21 (5) Any condition cited by a fire marshal, building official, or health authority as
335.22 hazardous or creating an immediate danger of fire or threat to health and safety must be
335.23 corrected before a license is issued by the department, and for community residential
335.24 settings, before a license is reissued.

335.25 (c) The facility must maintain in a permanent file the reports of health, fire, and
335.26 other safety inspections.

335.27 (d) The facility's plumbing, ventilation, heating, cooling, lighting, and other
335.28 fixtures and equipment, including elevators or food service, if provided, must conform to
335.29 applicable health, sanitation, and safety codes and regulations.

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

335.31 Sec. 33. **[245D.22] FACILITY SANITATION AND HEALTH.**

335.32 Subdivision 1. **General maintenance.** The license holder must maintain the interior
335.33 and exterior of buildings, structures, or enclosures used by the facility, including walls,
335.34 floors, ceilings, registers, fixtures, equipment, and furnishings in good repair and in a
335.35 sanitary and safe condition. The facility must be clean and free from accumulations of

336.1 dirt, grease, garbage, peeling paint, mold, vermin, and insects. The license holder must
336.2 correct building and equipment deterioration, safety hazards, and unsanitary conditions.
336.3 Subd. 2. **Hazards and toxic substances.** The license holder must ensure that
336.4 service sites owned or leased by the license holder are free from hazards that would
336.5 threaten the health or safety of a person receiving services by ensuring the requirements
336.6 in paragraphs (a) to (g) are met.
336.7 (a) Chemicals, detergents, and other hazardous or toxic substances must not be
336.8 stored with food products or in any way that poses a hazard to persons receiving services.
336.9 (b) The license holder must install handrails and nonslip surfaces on interior and
336.10 exterior runways, stairways, and ramps according to the applicable building code.
336.11 (c) If there are elevators in the facility, the license holder must have elevators
336.12 inspected each year. The date of the inspection, any repairs needed, and the date the
336.13 necessary repairs were made must be documented.
336.14 (d) The license holder must keep stairways, ramps, and corridors free of obstructions.
336.15 (e) Outside property must be free from debris and safety hazards. Exterior stairs and
336.16 walkways must be kept free of ice and snow.
336.17 (f) Heating, ventilation, air conditioning units, and other hot surfaces and moving
336.18 parts of machinery must be shielded or enclosed.
336.19 (g) Use of dangerous items or equipment by persons served by the program must be
336.20 allowed in accordance with the person's coordinated service and support plan addendum
336.21 or the program abuse prevention plan, if not addressed in the coordinated service and
336.22 support plan addendum.
336.23 Subd. 3. **Storage and disposal of medication.** Schedule II controlled substances in
336.24 the facility that are named in section 152.02, subdivision 3, must be stored in a locked
336.25 storage area permitting access only by persons and staff authorized to administer the
336.26 medication. This must be incorporated into the license holder's medication administration
336.27 policy and procedures required under section 245D.11, subdivision 2, clause (3).
336.28 Medications must be disposed of according to the Environmental Protection Agency
336.29 recommendations.
336.30 Subd. 4. **First aid must be available on site.** (a) A staff person trained in first aid
336.31 must be available on site and, when required in a person's coordinated service and support
336.32 plan or coordinated service and support plan addendum, cardiopulmonary resuscitation,
336.33 whenever persons are present and staff are required to be at the site to provide direct
336.34 service. The training must include in-person instruction, hands-on practice, and an
336.35 observed skills assessment under the direct supervision of a first aid instructor.

337.1 (b) A facility must have first aid kits readily available for use by, and that meets
337.2 the needs of, persons receiving services and staff. At a minimum, the first aid kit must
337.3 be equipped with accessible first aid supplies including bandages, sterile compresses,
337.4 scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap,
337.5 adhesive tape, and first aid manual.

337.6 Subd. 5. **Emergencies.** (a) The license holder must have a written plan for
337.7 responding to emergencies as defined in section 245D.02, subdivision 8, to ensure the
337.8 safety of persons served in the facility. The plan must include:

337.9 (1) procedures for emergency evacuation and emergency sheltering, including:

337.10 (i) how to report a fire or other emergency;

337.11 (ii) procedures to notify, relocate, and evacuate occupants, including use of adaptive
337.12 procedures or equipment to assist with the safe evacuation of persons with physical or
337.13 sensory disabilities; and

337.14 (iii) instructions on closing off the fire area, using fire extinguishers, and activating
337.15 and responding to alarm systems;

337.16 (2) a floor plan that identifies:

337.17 (i) the location of fire extinguishers;

337.18 (ii) the location of audible or visual alarm systems, including but not limited to
337.19 manual fire alarm boxes, smoke detectors, fire alarm enunciators and controls, and
337.20 sprinkler systems;

337.21 (iii) the location of exits, primary and secondary evacuation routes, and accessible
337.22 egress routes, if any; and

337.23 (iv) the location of emergency shelter within the facility;

337.24 (3) a site plan that identifies:

337.25 (i) designated assembly points outside the facility;

337.26 (ii) the locations of fire hydrants; and

337.27 (iii) the routes of fire department access;

337.28 (4) the responsibilities each staff person must assume in case of emergency;

337.29 (5) procedures for conducting quarterly drills each year and recording the date of
337.30 each drill in the file of emergency plans;

337.31 (6) procedures for relocation or service suspension when services are interrupted
337.32 for more than 24 hours;

337.33 (7) for a community residential setting with three or more dwelling units, a floor
337.34 plan that identifies the location of enclosed exit stairs; and

337.35 (8) an emergency escape plan for each resident.

337.36 (b) The license holder must:

338.1 (1) maintain a log of quarterly fire drills on file in the facility;
338.2 (2) provide an emergency response plan that is readily available to staff and persons
338.3 receiving services;
338.4 (3) inform each person of a designated area within the facility where the person
338.5 should go to for emergency shelter during severe weather and the designated assembly
338.6 points outside the facility; and
338.7 (4) maintain emergency contact information for persons served at the facility that
338.8 can be readily accessed in an emergency.
338.9 Subd. 6. **Emergency equipment.** The facility must have a flashlight and a portable
338.10 radio or television set that do not require electricity and can be used if a power failure
338.11 occurs.
338.12 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin operated
338.13 telephone that is readily accessible. A list of emergency numbers must be posted in a
338.14 prominent location. When an area has a 911 number or a mental health crisis intervention
338.15 team number, both numbers must be posted and the emergency number listed must be
338.16 911. In areas of the state without a 911 number, the numbers listed must be those of the
338.17 local fire department, police department, emergency transportation, and poison control
338.18 center. The names and telephone numbers of each person's representative, physician, and
338.19 dentist must be readily available.

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

338.21 Sec. 34. **[245D.23] COMMUNITY RESIDENTIAL SETTINGS; SATELLITE**
338.22 **LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**
338.23 Subdivision 1. **Separate satellite license required for separate sites.** (a) A license
338.24 holder providing residential support services must obtain a separate satellite license for
338.25 each community residential setting located at separate addresses when the community
338.26 residential settings are to be operated by the same license holder. For purposes of this
338.27 chapter, a community residential setting is a satellite of the home and community-based
338.28 services license.
338.29 (b) Community residential settings are permitted single-family use homes. After a
338.30 license has been issued, the commissioner shall notify the local municipality where the
338.31 residence is located of the approved license.
338.32 Subd. 2. **Notification to local agency.** The license holder must notify the local
338.33 agency within 24 hours of the onset of changes in a residence resulting from construction,
338.34 remodeling, or damages requiring repairs that require a building permit or may affect a
338.35 licensing requirement in this chapter.

339.1 Subd. 3. **Alternate overnight supervision.** A license holder granted an alternate
339.2 overnight supervision technology adult foster care license according to section 245A.11,
339.3 subdivision 7a, that converts to a community residential setting satellite license according
339.4 to this chapter must retain that designation.

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

339.6 Sec. 35. **[245D.24] COMMUNITY RESIDENTIAL SETTINGS; PHYSICAL**
339.7 **PLANT AND ENVIRONMENT.**

339.8 Subdivision 1. **Occupancy.** The residence must meet the definition of a dwelling
339.9 unit in a residential occupancy.

339.10 Subd. 2. **Common area requirements.** The living area must be provided with an
339.11 adequate number of furnishings for the usual functions of daily living and social activities.
339.12 The dining area must be furnished to accommodate meals shared by all persons living in
339.13 the residence. These furnishings must be in good repair and functional to meet the daily
339.14 needs of the persons living in the residence.

339.15 Subd. 3. **Bedrooms.** (a) People receiving services must mutually consent, in
339.16 writing, to sharing a bedroom with one another. No more than two people receiving
339.17 services may share one bedroom.

339.18 (b) A single occupancy bedroom must have at least 80 square feet of floor space with
339.19 a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
339.20 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and
339.21 other habitable rooms by floor to ceiling walls containing no openings except doorways
339.22 and must not serve as a corridor to another room used in daily living.

339.23 (c) A person's personal possessions and items for the person's own use are the only
339.24 items permitted to be stored in a person's bedroom.

339.25 (d) Unless otherwise documented through assessment as a safety concern for the
339.26 person, each person must be provided with the following furnishings:

339.27 (1) a separate bed of proper size and height for the convenience and comfort of the
339.28 person, with a clean mattress in good repair;

339.29 (2) clean bedding appropriate for the season for each person;

339.30 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
339.31 possessions and clothing; and

339.32 (4) a mirror for grooming.

339.33 (e) When possible, a person must be allowed to have items of furniture that the
339.34 person personally owns in the bedroom, unless doing so would interfere with safety
339.35 precautions, violate a building or fire code, or interfere with another person's use of the

340.1 bedroom. A person may choose to not have a cabinet, dresser, shelves, or a mirror in the
340.2 bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may
340.3 choose to use a mattress other than an innerspring mattress and may choose to not have
340.4 the mattress on a mattress frame or support. If a person chooses not to have a piece of
340.5 required furniture, the license holder must document this choice and is not required to
340.6 provide the item. If a person chooses to use a mattress other than an innerspring mattress
340.7 or chooses to not have a mattress frame or support, the license holder must document this
340.8 choice and allow the alternative desired by the person.

340.9 (f) A person must be allowed to bring personal possessions into the bedroom
340.10 and other designated storage space, if such space is available, in the residence. The
340.11 person must be allowed to accumulate possessions to the extent the residence is able to
340.12 accommodate them, unless doing so is contraindicated for the person's physical or mental
340.13 health, would interfere with safety precautions or another person's use of the bedroom, or
340.14 would violate a building or fire code. The license holder must allow for locked storage
340.15 of personal items. Any restriction on the possession or locked storage of personal items,
340.16 including requiring a person to use a lock provided by the license holder, must comply
340.17 with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if
340.18 and when the license holder opens the lock.

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

340.20 Sec. 36. **[245D.25] COMMUNITY RESIDENTIAL SETTINGS; FOOD AND**
340.21 **WATER.**

340.22 Subdivision 1. **Water.** Potable water from privately owned wells must be tested
340.23 annually by a Department of Health-certified laboratory for coliform bacteria and nitrate
340.24 nitrogens to verify safety. The health authority may require retesting and corrective
340.25 measures if results exceed state water standards in Minnesota Rules, chapter 4720, or in
340.26 the event of a flooding or incident which may put the well at risk of contamination. To
340.27 prevent scalding, the water temperature of faucets must not exceed 120 degrees Fahrenheit.

340.28 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as
340.29 prescribed by the person's physician or dietitian. Three nutritionally balanced meals a day
340.30 must be served or made available to persons, and nutritious snacks must be available
340.31 between meals.

340.32 Subd. 3. **Food safety.** Food must be obtained, handled, and properly stored to
340.33 prevent contamination, spoilage, or a threat to the health of a person.

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

341.1 Sec. 37. **[245D.26] COMMUNITY RESIDENTIAL SETTINGS; SANITATION**
341.2 **AND HEALTH.**

341.3 Subdivision 1. **Goods provided by the license holder.** Individual clean bed linens
341.4 appropriate for the season and the person's comfort, including towels and wash cloths,
341.5 must be available for each person. Usual or customary goods for the operation of a
341.6 residence which are communally used by all persons receiving services living in the
341.7 residence must be provided by the license holder, including household items for meal
341.8 preparation, cleaning supplies to maintain the cleanliness of the residence, window
341.9 coverings on windows for privacy, toilet paper, and hand soap.

341.10 Subd. 2. **Personal items.** Personal health and hygiene items must be stored in a
341.11 safe and sanitary manner.

341.12 Subd. 3. **Pets and service animals.** Pets and service animals housed within
341.13 the residence must be immunized and maintained in good health as required by local
341.14 ordinances and state law. The license holder must ensure that the person and the person's
341.15 representative is notified before admission of the presence of pets in the residence.

341.16 Subd. 4. **Smoking in the residence.** License holders must comply with the
341.17 requirements of the Minnesota Clean Indoor Air Act, sections 144.411 to 144.417, when
341.18 smoking is permitted in the residence.

341.19 Subd. 5. **Weapons.** Weapons and ammunition must be stored separately in locked
341.20 areas that are inaccessible to a person receiving services. For purposes of this subdivision,
341.21 "weapons" means firearms and other instruments or devices designed for and capable of
341.22 producing bodily harm.

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

341.24 Sec. 38. **[245D.27] DAY SERVICES FACILITIES; SATELLITE LICENSURE**
341.25 **REQUIREMENTS AND APPLICATION PROCESS.**

341.26 Except for day service facilities on the same or adjoining lot, the license holder
341.27 providing day services must apply for a separate license for each facility-based service
341.28 site when the license holder is the owner, lessor, or tenant of the service site at which
341.29 persons receive day services and the license holder's employees who provide day services
341.30 are present for a cumulative total of more than 30 days within any 12-month period. For
341.31 purposes of this chapter, a day services facility license is a satellite license of the day
341.32 services program. A day services program may operate multiple licensed day service
341.33 facilities in one or more counties in the state. For the purposes of this section, "adjoining
341.34 lot" means day services facilities that are next door to or across the street from one another.

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

342.2 Sec. 39. **[245D.28] DAY SERVICES FACILITIES; PHYSICAL PLANT AND**
342.3 **SPACE REQUIREMENTS.**

342.4 Subdivision 1. **Facility capacity and useable space requirements.** (a) The facility
342.5 capacity of each day service facility must be determined by the amount of primary space
342.6 available, the scheduling of activities at other service sites, and the space requirements of
342.7 all persons receiving services at the facility, not just the licensed services. The facility
342.8 capacity must specify the maximum number of persons that may receive services on
342.9 site at any one time.

342.10 (b) When a facility is located in a multifunctional organization, the facility may
342.11 share common space with the multifunctional organization if the required available
342.12 primary space for use by persons receiving day services is maintained while the facility is
342.13 operating. The license holder must comply at all times with all applicable fire and safety
342.14 codes under section 245A.04, subdivision 2a, and adequate supervision requirements
342.15 under section 245D.31 for all persons receiving day services.

342.16 (c) A day services facility must have a minimum of 40 square feet of primary space
342.17 available for each person who is present at the site at any one time. Primary space does
342.18 not include:

342.19 (1) common areas, such as hallways, stairways, closets, utility areas, bathrooms,
342.20 and kitchens;

342.21 (2) floor areas beneath stationary equipment; or

342.22 (3) any space occupied by persons associated with the multifunctional organization
342.23 while persons receiving day services are using common space.

342.24 Subd. 2. **Individual personal articles.** Each person must be provided space in a
342.25 closet, cabinet, on a shelf, or a coat hook for storage of personal items for the person's own
342.26 use while receiving services at the facility, unless doing so would interfere with safety
342.27 precautions, another person's work space, or violate a building or fire code.

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

342.29 Sec. 40. **[245D.29] DAY SERVICES FACILITIES; HEALTH AND SAFETY**
342.30 **REQUIREMENTS.**

342.31 Subdivision 1. **Refrigeration.** If the license holder provides refrigeration at service
342.32 sites owned or leased by the license holder for storing perishable foods and perishable
342.33 portions of bag lunches, whether the foods are supplied by the license holder or the

343.1 persons receiving services, the refrigeration must have a temperature of 40 degrees
343.2 Fahrenheit or less.

343.3 Subd. 2. **Drinking water.** Drinking water must be available to all persons
343.4 receiving services. If a person is unable to request or obtain drinking water, it must be
343.5 provided according to that person's individual needs. Drinking water must be provided in
343.6 single-service containers or from drinking fountains accessible to all persons.

343.7 Subd. 3. **Individuals who become ill during the day.** There must be an area in
343.8 which a person receiving services can rest if:

343.9 (1) the person becomes ill during the day;

343.10 (2) the person does not live in a licensed residential site;

343.11 (3) the person requires supervision; and

343.12 (4) there is not a caretaker immediately available. Supervision must be provided
343.13 until the caretaker arrives to bring the person home.

343.14 Subd. 4. **Safety procedures.** The license holder must establish general written
343.15 safety procedures that include criteria for selecting, training, and supervising persons who
343.16 work with hazardous machinery, tools, or substances. Safety procedures specific to each
343.17 person's activities must be explained and be available in writing to all staff members
343.18 and persons receiving services.

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

343.20 Sec. 41. **[245D.31] DAY SERVICES FACILITIES; STAFF RATIO AND**
343.21 **FACILITY COVERAGE.**

343.22 Subdivision 1. **Scope.** This section applies only to facility-based day services.

343.23 Subd. 2. **Factors.** (a) The number of direct support service staff members that a
343.24 license holder must have on duty at the facility at a given time to meet the minimum
343.25 staffing requirements established in this section varies according to:

343.26 (1) the number of persons who are enrolled and receiving direct support services
343.27 at that given time;

343.28 (2) the staff ratio requirement established under subdivision 3 for each person who
343.29 is present; and

343.30 (3) whether the conditions described in subdivision 8 exist and warrant additional
343.31 staffing beyond the number determined to be needed under subdivision 7.

343.32 (b) The commissioner must consider the factors in paragraph (a) in determining a
343.33 license holder's compliance with the staffing requirements and must further consider
343.34 whether the staff ratio requirement established under subdivision 3 for each person
343.35 receiving services accurately reflects the person's need for staff time.

344.1 Subd. 3. **Staff ratio requirement for each person receiving services.** The case
344.2 manager, in consultation with the interdisciplinary team, must determine at least once each
344.3 year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving
344.4 services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio
344.5 assigned each person and the documentation of how the ratio was arrived at must be kept
344.6 in each person's individual service plan. Documentation must include an assessment of the
344.7 person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard
344.8 assessment form required by the commissioner.

344.9 Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a
344.10 staff ratio requirement of one to four if:

344.11 (1) on a daily basis the person requires total care and monitoring or constant
344.12 hand-over-hand physical guidance to successfully complete at least three of the following
344.13 activities: toileting, communicating basic needs, eating, ambulating; or is not capable of
344.14 taking appropriate action for self-preservation under emergency conditions; or

344.15 (2) the person engages in conduct that poses an imminent risk of physical harm to
344.16 self or others at a documented level of frequency, intensity, or duration requiring frequent
344.17 daily ongoing intervention and monitoring as established in the person's coordinated
344.18 service and support plan or coordinated service and support plan addendum.

344.19 Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a
344.20 staff ratio requirement of one to eight if:

344.21 (1) the person does not meet the requirements in subdivision 4; and

344.22 (2) on a daily basis the person requires verbal prompts or spot checks and minimal
344.23 or no physical assistance to successfully complete at least four of the following activities:
344.24 toileting, communicating basic needs, eating, ambulating, or taking appropriate action for
344.25 self-preservation under emergency conditions.

344.26 Subd. 6. **Person requiring staff ratio of one to six.** A person who does not have
344.27 any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio
344.28 requirement of one to six.

344.29 Subd. 7. **Determining number of direct support service staff required.** The
344.30 minimum number of direct support service staff members required at any one time to
344.31 meet the combined staff ratio requirements of the persons present at that time can be
344.32 determined by the following steps:

344.33 (1) assign each person in attendance the three-digit decimal below that corresponds
344.34 to the staff ratio requirement assigned to that person. A staff ratio requirement of one to
344.35 four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio
344.36 requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

345.1 (2) add all of the three-digit decimals (one three-digit decimal for every person in
345.2 attendance) assigned in clause (1);

345.3 (3) when the sum in clause (2) falls between two whole numbers, round off the sum
345.4 to the larger of the two whole numbers; and

345.5 (4) the larger of the two whole numbers in clause (3) equals the number of direct
345.6 support service staff members needed to meet the staff ratio requirements of the persons
345.7 in attendance.

345.8 Subd. 8. **Staff to be included in calculating minimum staffing requirement.** Only
345.9 direct support staff must be counted as staff members in calculating the staff to participant
345.10 ratio. A volunteer may be counted as a direct support staff in calculating the staff to
345.11 participant ratio if the volunteer meets the same standards and requirements as paid staff.
345.12 No person receiving services must be counted as or be substituted for a staff member in
345.13 calculating the staff to participant ratio.

345.14 Subd. 9. **Conditions requiring additional direct support staff.** The license holder
345.15 must increase the number of direct support staff members present at any one time beyond
345.16 the number arrived at in subdivision 4 if necessary when any one or combination of the
345.17 following circumstances can be documented by the commissioner as existing:

345.18 (1) the health and safety needs of the persons receiving services cannot be met by
345.19 the number of staff members available under the staffing pattern in effect even though the
345.20 number has been accurately calculated under subdivision 7; or

345.21 (2) the person's conduct frequently presents an imminent risk of physical harm to
345.22 self or others.

345.23 Subd. 10. **Supervision requirements.** (a) At no time must one direct support
345.24 staff member be assigned responsibility for supervision and training of more than ten
345.25 persons receiving supervision and training, except as otherwise stated in each person's risk
345.26 management plan.

345.27 (b) In the temporary absence of the director or a supervisor, a direct support staff
345.28 member must be designated to supervise the center.

345.29 Subd. 11. **Multifunctional programs.** A multifunctional program may count other
345.30 employees of the organization besides direct support staff of the day service facility in
345.31 calculating the staff to participant ratio if the employee is assigned to the day services
345.32 facility for a specified amount of time, during which the employee is not assigned to
345.33 another organization or program.

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

345.35 Sec. 42. **[245D.32] ALTERNATIVE LICENSING INSPECTIONS.**

346.1 Subdivision 1. **Eligibility for an alternative licensing inspection.** (a) A license
346.2 holder providing services licensed under this chapter, with a qualifying accreditation and
346.3 meeting the eligibility criteria in paragraphs (b) and (c) may request approval for an
346.4 alternative licensing inspection when all services provided under the license holder's
346.5 license are accredited. A license holder with a qualifying accreditation and meeting
346.6 the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative
346.7 licensing inspection for individual community residential settings or day services facilities
346.8 licensed under this chapter.

346.9 (b) In order to be eligible for an alternative licensing inspection, the program must
346.10 have had at least one inspection by the commissioner following issuance of the initial
346.11 license. For programs operating a day services facility, each facility must have had at least
346.12 one on-site inspection by the commissioner following issuance of the initial license.

346.13 (c) In order to be eligible for an alternative licensing inspection, the program must
346.14 have been in "substantial and consistent compliance" at the time of the last licensing
346.15 inspection and during the current licensing period. For purposes of this section, substantial
346.16 and consistent compliance means:

346.17 (1) the license holder's license was not made conditional, suspended, or revoked;

346.18 (2) there have been no substantiated allegations of maltreatment against the license
346.19 holder;

346.20 (3) there were no program deficiencies identified that would jeopardize the health,
346.21 safety, or rights of persons being served; and

346.22 (4) the license holder maintained substantial compliance with the other requirements
346.23 of chapters 245A and 245C and other applicable laws and rules.

346.24 (d) For the purposes of this section, the license holder's license includes services
346.25 licensed under this chapter that were previously licensed under chapter 245B until
346.26 December 31, 2013.

346.27 Subd. 2. **Qualifying accreditation.** The commissioner must accept a three-year
346.28 accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)
346.29 as a qualifying accreditation.

346.30 Subd. 3. **Request for approval of an alternative inspection status.** (a) A request
346.31 for an alternative inspection must be made on the forms and in the manner prescribed
346.32 by the commissioner. When submitting the request, the license holder must submit all
346.33 documentation issued by the accrediting body verifying that the license holder has obtained
346.34 and maintained the qualifying accreditation and has complied with recommendations
346.35 or requirements from the accrediting body during the period of accreditation. Based

347.1 on the request and the additional required materials, the commissioner may approve
347.2 an alternative inspection status.

347.3 (b) The commissioner must notify the license holder in writing that the request for
347.4 an alternative inspection status has been approved. Approval must be granted until the
347.5 end of the qualifying accreditation period.

347.6 (c) The license holder must submit a written request for approval to be renewed
347.7 one month before the end of the current approval period according to the requirements
347.8 in paragraph (a). If the license holder does not submit a request to renew approval as
347.9 required, the commissioner must conduct a licensing inspection.

347.10 Subd. 4. **Programs approved for alternative licensing inspection; deemed**
347.11 **compliance licensing requirements.** (a) A license holder approved for alternative
347.12 licensing inspection under this section is required to maintain compliance with all
347.13 licensing standards according to this chapter.

347.14 (b) A license holder approved for alternative licensing inspection under this section
347.15 must be deemed to be in compliance with all the requirements of this chapter, and the
347.16 commissioner must not perform routine licensing inspections.

347.17 (c) Upon receipt of a complaint regarding the services of a license holder approved
347.18 for alternative licensing inspection under this section, the commissioner must investigate
347.19 the complaint and may take any action as provided under section 245A.06 or 245A.07.

347.20 Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this
347.21 section changes the commissioner's responsibilities to investigate alleged or suspected
347.22 maltreatment of a minor under section 626.556 or a vulnerable adult under section 626.557.

347.23 Subd. 6. **Termination or denial of subsequent approval.** Following approval of
347.24 an alternative licensing inspection, the commissioner may terminate or deny subsequent
347.25 approval of an alternative licensing inspection if the commissioner determines that:

347.26 (1) the license holder has not maintained the qualifying accreditation;

347.27 (2) the commissioner has substantiated maltreatment for which the license holder or
347.28 facility is determined to be responsible during the qualifying accreditation period; or

347.29 (3) during the qualifying accreditation period, the license holder has been issued
347.30 an order for conditional license, fine, suspension, or license revocation that has not been
347.31 reversed upon appeal.

347.32 Subd. 7. **Appeals.** The commissioner's decision that the conditions for approval for
347.33 an alternative licensing inspection have not been met is final and not subject to appeal
347.34 under the provisions of chapter 14.

348.1 Subd. 8. **Commissioner's programs.** Home and community-based services licensed
348.2 under this chapter for which the commissioner is the license holder with a qualifying
348.3 accreditation are excluded from being approved for an alternative licensing inspection.

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

348.5 Sec. 43. **[245D.33] ADULT MENTAL HEALTH CERTIFICATION STANDARDS.**

348.6 (a) The commissioner of human services shall issue a mental health certification
348.7 for services licensed under this chapter, when a license holder is determined to have met
348.8 the requirements under paragraph (b). This certification is voluntary for license holders.
348.9 The certification shall be printed on the license and identified on the commissioner's
348.10 public Web site.

348.11 (b) The requirements for certification are:

348.12 (1) all staff have received at least seven hours of annual training covering all of
348.13 the following topics:

348.14 (i) mental health diagnoses;

348.15 (ii) mental health crisis response and de-escalation techniques;

348.16 (iii) recovery from mental illness;

348.17 (iv) treatment options, including evidence-based practices;

348.18 (v) medications and their side effects;

348.19 (vi) co-occurring substance abuse and health conditions; and

348.20 (vii) community resources;

348.21 (2) a mental health professional, as defined in section 245.462, subdivision 18, or a
348.22 mental health practitioner as defined in section 245.462, subdivision 17, is available
348.23 for consultation and assistance;

348.24 (3) there is a plan and protocol in place to address a mental health crisis; and

348.25 (4) each person's individual service and support plan identifies who is providing
348.26 clinical services and their contact information, and includes an individual crisis prevention
348.27 and management plan developed with the person.

348.28 (c) License holders seeking certification under this section must request this
348.29 certification on forms and in the manner prescribed by the commissioner.

348.30 (d) If the commissioner finds that the license holder has failed to comply with the
348.31 certification requirements under paragraph (b), the commissioner may issue a correction
348.32 order and an order of conditional license in accordance with section 245A.06 or may
348.33 issue a sanction in accordance with section 245A.07, including and up to removal of
348.34 the certification.

349.1 (e) A denial of the certification or the removal of the certification based on a
349.2 determination that the requirements under paragraph (b) have not been met is not subject to
349.3 appeal. A license holder that has been denied a certification or that has had a certification
349.4 removed may again request certification when the license holder is in compliance with the
349.5 requirements of paragraph (b).

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

349.7 Sec. 44. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:
349.8 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
349.9 established a new service called residential support that is available on the community
349.10 alternative care, community alternatives for disabled individuals, developmental
349.11 disabilities, and brain injury waivers. Existing waiver service descriptions must be
349.12 modified to the extent necessary to ensure there is no duplication between other services.
349.13 Residential support services must be provided by vendors licensed as a community
349.14 residential setting as defined in section 245A.11, subdivision 8, a foster care setting
349.15 licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care
349.16 setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.
349.17 (b) Residential support services must meet the following criteria:
349.18 ~~(1) providers of residential support services must own or control the residential site;~~
349.19 ~~(2) the residential site must not be the primary residence of the license holder;~~
349.20 ~~(3)~~ (1) the residential site must have a designated ~~program supervisor~~ person
349.21 responsible for program management, oversight, development, and implementation of
349.22 policies and procedures;
349.23 ~~(4)~~ (2) the provider of residential support services must provide supervision, training,
349.24 and assistance as described in the person's coordinated service and support plan; and
349.25 ~~(5)~~ (3) the provider of residential support services must meet the requirements of
349.26 licensure and additional requirements of the person's coordinated service and support plan.
349.27 (c) Providers of residential support services that meet the definition in paragraph (a)
349.28 ~~must be registered using a process determined by the commissioner beginning July 1, 2009~~
349.29 must be licensed according to chapter 245D. Providers licensed to provide child foster care
349.30 under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under
349.31 Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section
349.32 245A.03, subdivision 7, paragraph (g), are considered registered under this section.

349.33 Sec. 45. Minnesota Statutes 2012, section 256B.4912, subdivision 1, is amended to read:

350.1 Subdivision 1. **Provider qualifications.** (a) For the home and community-based
350.2 waivers providing services to seniors and individuals with disabilities under sections
350.3 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:
350.4 (1) agreements with enrolled waiver service providers to ensure providers meet
350.5 Minnesota health care program requirements;
350.6 (2) regular reviews of provider qualifications, and including requests of proof of
350.7 documentation; and
350.8 (3) processes to gather the necessary information to determine provider qualifications.
350.9 (b) Beginning July 1, 2012, staff that provide direct contact, as defined in section
350.10 245C.02, subdivision 11, for services specified in the federally approved waiver plans
350.11 must meet the requirements of chapter 245C prior to providing waiver services and as
350.12 part of ongoing enrollment. Upon federal approval, this requirement must also apply to
350.13 consumer-directed community supports.
350.14 (c) Beginning January 1, 2014, service owners and managerial officials overseeing
350.15 the management or policies of services that provide direct contact as specified in the
350.16 federally approved waiver plans must meet the requirements of chapter 245C prior to
350.17 reenrollment or, for new providers, prior to initial enrollment if they have not already done
350.18 so as a part of service licensure requirements.

350.19 Sec. 46. Minnesota Statutes 2012, section 256B.4912, subdivision 7, is amended to read:
350.20 Subd. 7. **Applicant and license holder training.** An applicant or license holder
350.21 for the home and community-based waivers providing services to seniors and individuals
350.22 with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is
350.23 not enrolled as a Minnesota health care program home and community-based services
350.24 waiver provider at the time of application must ensure that at least one controlling
350.25 individual completes a onetime training on the requirements for providing home and
350.26 community-based services ~~from a qualified source~~ as determined by the commissioner,
350.27 before a provider is enrolled or license is issued. Within six months of enrollment, a newly
350.28 enrolled home and community-based waiver service provider must ensure that at least one
350.29 controlling individual has completed training on waiver and related program billing.

350.30 Sec. 47. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
350.31 subdivision to read:
350.32 Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1,
350.33 2013, facilities and services to be licensed under chapter 245D shall submit data regarding

351.1 the use of emergency use of manual restraint as identified in section 245D.061 in a format
351.2 and at a frequency identified by the commissioner.

351.3 Sec. 48. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
351.4 subdivision to read:

351.5 Subd. 9. **Definitions.** (a) For the purposes of this section the following terms have
351.6 the meanings given them.

351.7 (b) "Controlling individual" means a public body, governmental agency, business
351.8 entity, officer, owner, or managerial official whose responsibilities include the direction of
351.9 the management or policies of a program.

351.10 (c) "Managerial official" means an individual who has decision-making authority
351.11 related to the operation of the program and responsibility for the ongoing management of
351.12 or direction of the policies, services, or employees of the program.

351.13 (d) "Owner" means an individual who has direct or indirect ownership interest in
351.14 a corporation or partnership, or business association enrolling with the Department of
351.15 Human Services as a provider of waiver services.

351.16 Sec. 49. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
351.17 subdivision to read:

351.18 Subd. 10. **Enrollment requirements.** All home and community-based waiver
351.19 providers must provide, at the time of enrollment and within 30 days of a request, in a
351.20 format determined by the commissioner, information and documentation that includes, but
351.21 is not limited to, the following:

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

351.24 (2) proof of fidelity bond coverage in the amount of $20,000; and

351.25 (3) proof of liability insurance.

351.26 Sec. 50. Minnesota Statutes 2012, section 626.557, subdivision 9a, is amended to read:

351.27 Subd. 9a. **Evaluation and referral of reports made to common entry point unit.**
351.28 The common entry point must screen the reports of alleged or suspected maltreatment for
351.29 immediate risk and make all necessary referrals as follows:

351.30 (1) if the common entry point determines that there is an immediate need for
351.31 adult protective services, the common entry point agency shall immediately notify the
351.32 appropriate county agency;

(2) if the report contains suspected criminal activity against a vulnerable adult, the common entry point shall immediately notify the appropriate law enforcement agency;

(3) the common entry point shall refer all reports of alleged or suspected maltreatment to the appropriate lead investigative agency as soon as possible, but in any event no longer than two working days; and

~~(4) if the report involves services licensed by the Department of Human Services and subject to chapter 245D, the common entry point shall refer the report to the county as the lead agency according to clause (3), but shall also notify the Department of Human Services of the report; and~~

~~(5)~~ (4) if the report contains information about a suspicious death, the common entry point shall immediately notify the appropriate law enforcement agencies, the local medical examiner, and the ombudsman for mental health and developmental disabilities established under section 245.92. Law enforcement agencies shall coordinate with the local medical examiner and the ombudsman as provided by law.

Sec. 51. Minnesota Statutes 2012, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home, whether a private home or a housing with services establishment registered under chapter 144D, including those that offer assisted living services under chapter 144G.

(b) ~~Except as provided under paragraph (c), for services licensed according to chapter 245D,~~ The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, programs for people with developmental disabilities, family adult day services, mental health programs, mental health clinics, chemical dependency programs, the Minnesota sex offender program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services.

353.1 (c) The county social service agency or its designee is the lead investigative agency
353.2 for all other reports, including, but not limited to, reports involving vulnerable adults
353.3 receiving services from a personal care provider organization under section 256B.0659~~,~~
353.4 ~~or receiving home and community-based services licensed by the Department of Human~~
353.5 ~~Services and subject to chapter 245D~~.

353.6 Sec. 52. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
353.7 **AND COMMUNITY-BASED SERVICES.**

353.8 (a) The Department of Health Compliance Monitoring Division and the Department
353.9 of Human Services Licensing Division shall jointly develop an integrated licensing system
353.10 for providers of both home care services subject to licensure under Minnesota Statutes,
353.11 chapter 144A, and for home and community-based services subject to licensure under
353.12 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

353.13 (1) require only one license of any provider of services under Minnesota Statutes,
353.14 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

353.15 (2) promote quality services that recognize a person's individual needs and protect
353.16 the person's health, safety, rights, and well-being;

353.17 (3) promote provider accountability through application requirements, compliance
353.18 inspections, investigations, and enforcement actions;

353.19 (4) reference other applicable requirements in existing state and federal laws,
353.20 including the federal Affordable Care Act;

353.21 (5) establish internal procedures to facilitate ongoing communications between the
353.22 agencies, and with providers and services recipients about the regulatory activities;

353.23 (6) create a link between the agency Web sites so that providers and the public can
353.24 access the same information regardless of which Web site is accessed initially; and

353.25 (7) collect data on identified outcome measures as necessary for the agencies to
353.26 report to the Centers for Medicare and Medicaid Services.

353.27 (b) The joint recommendations for legislative changes to implement the integrated
353.28 licensing system are due to the legislature by February 15, 2014.

353.29 (c) Before implementation of the integrated licensing system, providers licensed as
353.30 home care providers under Minnesota Statutes, chapter 144A, may also provide home
353.31 and community-based services subject to licensure under Minnesota Statutes, chapter
353.32 245D, without obtaining a home and community-based services license under Minnesota
353.33 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
353.34 apply to these providers:

(1) the provider must comply with all requirements under Minnesota Statutes, chapter 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

(2) a violation of requirements under Minnesota Statutes, chapter 245D, may be enforced by the Department of Health under the enforcement authority set forth in Minnesota Statutes, section 144A.475; and

(3) the Department of Health will provide information to the Department of Human Services about each provider licensed under this section, including the provider's license application, licensing documents, inspections, information about complaints received, and investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

Sec. 53. **REPEALER.**

(a) Minnesota Statutes 2012, sections 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, and 7; 245B.055; 245B.06; 245B.07; and 245B.08, are repealed effective January 1, 2014.

(b) Minnesota Statutes 2012, section 245D.08, is repealed.

ARTICLE 10

WAIVER PROVIDER STANDARDS TECHNICAL CHANGES

Section 1. Minnesota Statutes 2012, section 16C.10, subdivision 5, is amended to read:

Subd. 5. **Specific purchases.** The solicitation process described in this chapter is not required for acquisition of the following:

(1) merchandise for resale purchased under policies determined by the commissioner;

(2) farm and garden products which, as determined by the commissioner, may be purchased at the prevailing market price on the date of sale;

(3) goods and services from the Minnesota correctional facilities;

(4) goods and services from rehabilitation facilities and extended employment providers that are certified by the commissioner of employment and economic development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D;

(5) goods and services for use by a community-based facility operated by the commissioner of human services;

(6) goods purchased at auction or when submitting a sealed bid at auction provided that before authorizing such an action, the commissioner consult with the requesting agency to determine a fair and reasonable value for the goods considering factors including, but not limited to, costs associated with submitting a bid, travel, transportation, and storage. This fair and reasonable value must represent the limit of the state's bid;

355.1 (7) utility services where no competition exists or where rates are fixed by law or
355.2 ordinance; and
355.3 (8) goods and services from Minnesota sex offender program facilities.

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

355.5 Sec. 2. Minnesota Statutes 2012, section 16C.155, subdivision 1, is amended to read:
355.6 Subdivision 1. **Service contracts.** The commissioner of administration shall
355.7 ensure that a portion of all contracts for janitorial services; document imaging;
355.8 document shredding; and mailing, collating, and sorting services be awarded by the
355.9 state to rehabilitation programs and extended employment providers that are certified
355.10 by the commissioner of employment and economic development, and day ~~training and~~
355.11 ~~habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D. The
355.12 amount of each contract awarded under this section may exceed the estimated fair market
355.13 price as determined by the commissioner for the same goods and services by up to six
355.14 percent. The aggregate value of the contracts awarded to eligible providers under this
355.15 section in any given year must exceed 19 percent of the total value of all contracts for
355.16 janitorial services; document imaging; document shredding; and mailing, collating, and
355.17 sorting services entered into in the same year. For the 19 percent requirement to be
355.18 applicable in any given year, the contract amounts proposed by eligible providers must be
355.19 within six percent of the estimated fair market price for at least 19 percent of the contracts
355.20 awarded for the corresponding service area.

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

355.22 Sec. 3. Minnesota Statutes 2012, section 144D.01, subdivision 4, is amended to read:
355.23 Subd. 4. **Housing with services establishment or establishment.** (a) "Housing
355.24 with services establishment" or "establishment" means:
355.25 (1) an establishment providing sleeping accommodations to one or more adult
355.26 residents, at least 80 percent of which are 55 years of age or older, and offering or
355.27 providing, for a fee, one or more regularly scheduled health-related services or two or
355.28 more regularly scheduled supportive services, whether offered or provided directly by the
355.29 establishment or by another entity arranged for by the establishment; or
355.30 (2) an establishment that registers under section 144D.025.
355.31 (b) Housing with services establishment does not include:
355.32 (1) a nursing home licensed under chapter 144A;

356.1 (2) a hospital, certified boarding care home, or supervised living facility licensed
356.2 under sections 144.50 to 144.56;
356.3 (3) a board and lodging establishment licensed under chapter 157 and Minnesota
356.4 Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660,
356.5 or 9530.4100 to 9530.4450, or under chapter ~~245B~~ 245D;
356.6 (4) a board and lodging establishment which serves as a shelter for battered women
356.7 or other similar purpose;
356.8 (5) a family adult foster care home licensed by the Department of Human Services;
356.9 (6) private homes in which the residents are related by kinship, law, or affinity with
356.10 the providers of services;
356.11 (7) residential settings for persons with developmental disabilities in which the
356.12 services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable
356.13 successor rules or laws;
356.14 (8) a home-sharing arrangement such as when an elderly or disabled person or
356.15 single-parent family makes lodging in a private residence available to another person
356.16 in exchange for services or rent, or both;
356.17 (9) a duly organized condominium, cooperative, common interest community, or
356.18 owners' association of the foregoing where at least 80 percent of the units that comprise the
356.19 condominium, cooperative, or common interest community are occupied by individuals
356.20 who are the owners, members, or shareholders of the units; or
356.21 (10) services for persons with developmental disabilities that are provided under
356.22 a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until
356.23 January 1, 1998, or under chapter ~~245B~~ 245D.

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

356.25 Sec. 4. Minnesota Statutes 2012, section 174.30, subdivision 1, is amended to read:
356.26 Subdivision 1. **Applicability.** (a) The operating standards for special transportation
356.27 service adopted under this section do not apply to special transportation provided by:
356.28 (1) a common carrier operating on fixed routes and schedules;
356.29 (2) a volunteer driver using a private automobile;
356.30 (3) a school bus as defined in section 169.011, subdivision 71; or
356.31 (4) an emergency ambulance regulated under chapter 144.
356.32 (b) The operating standards adopted under this section only apply to providers
356.33 of special transportation service who receive grants or other financial assistance from
356.34 either the state or the federal government, or both, to provide or assist in providing that
356.35 service; except that the operating standards adopted under this section do not apply

357.1 to any nursing home licensed under section 144A.02, to any board and care facility
357.2 licensed under section 144.50, or to any day training and habilitation services, day care,
357.3 or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or
357.4 program provides transportation to nonresidents on a regular basis and the facility receives
357.5 reimbursement, other than per diem payments, for that service under rules promulgated
357.6 by the commissioner of human services.
357.7 (c) Notwithstanding paragraph (b), the operating standards adopted under this
357.8 section do not apply to any vendor of services licensed under chapter ~~245B~~ 245D that
357.9 provides transportation services to consumers or residents of other vendors licensed under
357.10 chapter ~~245B~~ 245D and transports 15 or fewer persons, including consumers or residents
357.11 and the driver.

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

357.13 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 1, is amended to read:
357.14 Subdivision 1. **Scope.** The terms used in this chapter ~~and chapter 245B~~ have the
357.15 meanings given them in this section.

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

357.17 Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 9, is amended to read:
357.18 Subd. 9. **License holder.** "License holder" means an individual, corporation,
357.19 partnership, voluntary association, or other organization that is legally responsible for the
357.20 operation of the program, has been granted a license by the commissioner under this chapter
357.21 or chapter ~~245B~~ 245D and the rules of the commissioner, and is a controlling individual.

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

357.23 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:
357.24 Subd. 9. **Permitted services by an individual who is related.** Notwithstanding
357.25 subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a
357.26 person receiving supported living services may provide licensed services to that person if:
357.27 (1) the person who receives supported living services received these services in a
357.28 residential site on July 1, 2005;
357.29 (2) the services under clause (1) were provided in a corporate foster care setting for
357.30 adults and were funded by the developmental disabilities home and community-based
357.31 services waiver defined in section 256B.092;

358.1 (3) the individual who is related obtains and maintains both a license under chapter
358.2 ~~245B~~ 245D and an adult foster care license under Minnesota Rules, parts 9555.5105
358.3 to 9555.6265; and
358.4 (4) the individual who is related is not the guardian of the person receiving supported
358.5 living services.

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

358.7 Sec. 8. Minnesota Statutes 2012, section 245A.04, subdivision 13, is amended to read:
358.8 Subd. 13. **Funds and property; other requirements.** (a) A license holder must
358.9 ensure that persons served by the program retain the use and availability of personal funds
358.10 or property unless restrictions are justified in the person's individual plan. ~~This subdivision~~
358.11 ~~does not apply to programs governed by the provisions in section 245B.07, subdivision 10.~~
358.12 (b) The license holder must ensure separation of funds of persons served by the
358.13 program from funds of the license holder, the program, or program staff.
358.14 (c) Whenever the license holder assists a person served by the program with the
358.15 safekeeping of funds or other property, the license holder must:
358.16 (1) immediately document receipt and disbursement of the person's funds or other
358.17 property at the time of receipt or disbursement, including the person's signature, or the
358.18 signature of the conservator or payee; and
358.19 (2) return to the person upon the person's request, funds and property in the license
358.20 holder's possession subject to restrictions in the person's treatment plan, as soon as
358.21 possible, but no later than three working days after the date of request.
358.22 (d) License holders and program staff must not:
358.23 (1) borrow money from a person served by the program;
358.24 (2) purchase personal items from a person served by the program;
358.25 (3) sell merchandise or personal services to a person served by the program;
358.26 (4) require a person served by the program to purchase items for which the license
358.27 holder is eligible for reimbursement; or
358.28 (5) use funds of persons served by the program to purchase items for which the
358.29 facility is already receiving public or private payments.

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

358.31 Sec. 9. Minnesota Statutes 2012, section 245A.07, subdivision 3, is amended to read:
358.32 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may
358.33 suspend or revoke a license, or impose a fine if:

359.1 (1) a license holder fails to comply fully with applicable laws or rules;
359.2 (2) a license holder, a controlling individual, or an individual living in the household
359.3 where the licensed services are provided or is otherwise subject to a background study has
359.4 a disqualification which has not been set aside under section 245C.22;
359.5 (3) a license holder knowingly withholds relevant information from or gives false
359.6 or misleading information to the commissioner in connection with an application for
359.7 a license, in connection with the background study status of an individual, during an
359.8 investigation, or regarding compliance with applicable laws or rules; or
359.9 (4) after July 1, 2012, and upon request by the commissioner, a license holder fails
359.10 to submit the information required of an applicant under section 245A.04, subdivision 1,
359.11 paragraph (f) or (g).
359.12 A license holder who has had a license suspended, revoked, or has been ordered
359.13 to pay a fine must be given notice of the action by certified mail or personal service. If
359.14 mailed, the notice must be mailed to the address shown on the application or the last
359.15 known address of the license holder. The notice must state the reasons the license was
359.16 suspended, revoked, or a fine was ordered.
359.17 (b) If the license was suspended or revoked, the notice must inform the license
359.18 holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
359.19 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
359.20 a license. The appeal of an order suspending or revoking a license must be made in writing
359.21 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
359.22 the commissioner within ten calendar days after the license holder receives notice that the
359.23 license has been suspended or revoked. If a request is made by personal service, it must be
359.24 received by the commissioner within ten calendar days after the license holder received
359.25 the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits
359.26 a timely appeal of an order suspending or revoking a license, the license holder may
359.27 continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs
359.28 (g) and (h), until the commissioner issues a final order on the suspension or revocation.
359.29 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the
359.30 license holder of the responsibility for payment of fines and the right to a contested case
359.31 hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal
359.32 of an order to pay a fine must be made in writing by certified mail or personal service. If
359.33 mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
359.34 days after the license holder receives notice that the fine has been ordered. If a request is
359.35 made by personal service, it must be received by the commissioner within ten calendar
359.36 days after the license holder received the order.

360.1 (2) The license holder shall pay the fines assessed on or before the payment date
360.2 specified. If the license holder fails to fully comply with the order, the commissioner
360.3 may issue a second fine or suspend the license until the license holder complies. If the
360.4 license holder receives state funds, the state, county, or municipal agencies or departments
360.5 responsible for administering the funds shall withhold payments and recover any payments
360.6 made while the license is suspended for failure to pay a fine. A timely appeal shall stay
360.7 payment of the fine until the commissioner issues a final order.

360.8 (3) A license holder shall promptly notify the commissioner of human services,
360.9 in writing, when a violation specified in the order to forfeit a fine is corrected. If upon
360.10 reinspection the commissioner determines that a violation has not been corrected as
360.11 indicated by the order to forfeit a fine, the commissioner may issue a second fine. The
360.12 commissioner shall notify the license holder by certified mail or personal service that a
360.13 second fine has been assessed. The license holder may appeal the second fine as provided
360.14 under this subdivision.

360.15 (4) Fines shall be assessed as follows: the license holder shall forfeit $1,000 for
360.16 each determination of maltreatment of a child under section 626.556 or the maltreatment
360.17 of a vulnerable adult under section 626.557 for which the license holder is determined
360.18 responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i),
360.19 or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit $200 for each
360.20 occurrence of a violation of law or rule governing matters of health, safety, or supervision,
360.21 including but not limited to the provision of adequate staff-to-child or adult ratios, and
360.22 failure to comply with background study requirements under chapter 245C; and the license
360.23 holder shall forfeit $100 for each occurrence of a violation of law or rule other than
360.24 those subject to a $1,000 or $200 fine above. For purposes of this section, "occurrence"
360.25 means each violation identified in the commissioner's fine order. Fines assessed against a
360.26 license holder that holds a license to provide ~~the residential-based habilitation~~ home and
360.27 community-based services, as ~~defined under~~ identified in section ~~245B.02, subdivision~~
360.28 ~~20~~ 245D.03, subdivision 1, and a community residential setting or day services facility
360.29 license ~~to provide foster care~~ under chapter 245D where the services are provided, may be
360.30 assessed against both licenses for the same occurrence, but the combined amount of the
360.31 fines shall not exceed the amount specified in this clause for that occurrence.

360.32 (5) When a fine has been assessed, the license holder may not avoid payment by
360.33 closing, selling, or otherwise transferring the licensed program to a third party. In such an
360.34 event, the license holder will be personally liable for payment. In the case of a corporation,
360.35 each controlling individual is personally and jointly liable for payment.

361.1 (d) Except for background study violations involving the failure to comply with an
361.2 order to immediately remove an individual or an order to provide continuous, direct
361.3 supervision, the commissioner shall not issue a fine under paragraph (c) relating to a
361.4 background study violation to a license holder who self-corrects a background study
361.5 violation before the commissioner discovers the violation. A license holder who has
361.6 previously exercised the provisions of this paragraph to avoid a fine for a background
361.7 study violation may not avoid a fine for a subsequent background study violation unless at
361.8 least 365 days have passed since the license holder self-corrected the earlier background
361.9 study violation.

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

361.11 Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 19c, is amended to
361.12 read:

361.13 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance
361.14 services provided by an individual who is qualified to provide the services according to
361.15 subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a
361.16 plan, and supervised by a qualified professional.

361.17 "Qualified professional" means a mental health professional as defined in section
361.18 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);
361.19 ~~or~~ a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker
361.20 as defined in sections 148E.010 and 148E.055, or a qualified ~~developmental disabilities~~
361.21 ~~specialist under section 245B.07, subdivision 4~~ designated coordinator under section
361.22 245D.081, subdivision 2. The qualified professional shall perform the duties required in
361.23 section 256B.0659.

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

361.25 Sec. 11. Minnesota Statutes 2012, section 256B.5011, subdivision 2, is amended to read:

361.26 Subd. 2. **Contract provisions.** (a) The service contract with each intermediate
361.27 care facility must include provisions for:

361.28 (1) modifying payments when significant changes occur in the needs of the
361.29 consumers;

361.30 (2) appropriate and necessary statistical information required by the commissioner;

361.31 (3) annual aggregate facility financial information; and

361.32 (4) additional requirements for intermediate care facilities not meeting the standards
361.33 set forth in the service contract.

362.1 (b) The commissioner of human services and the commissioner of health, in
362.2 consultation with representatives from counties, advocacy organizations, and the provider
362.3 community, shall review ~~the consolidated standards under chapter 245B and~~ the home and
362.4 community-based services standards under chapter 245D and the supervised living facility
362.5 rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota
362.6 Rules, chapter 4665, may be waived by the commissioner of health for intermediate care
362.7 facilities in order to enable facilities to implement the performance measures in their
362.8 contract and provide quality services to residents without a duplication of or increase in
362.9 regulatory requirements.

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

362.11 Sec. 12. Minnesota Statutes 2012, section 471.59, subdivision 1, is amended to read:
362.12 Subdivision 1. **Agreement.** Two or more governmental units, by agreement entered
362.13 into through action of their governing bodies, may jointly or cooperatively exercise
362.14 any power common to the contracting parties or any similar powers, including those
362.15 which are the same except for the territorial limits within which they may be exercised.
362.16 The agreement may provide for the exercise of such powers by one or more of the
362.17 participating governmental units on behalf of the other participating units. The term
362.18 "governmental unit" as used in this section includes every city, county, town, school
362.19 district, independent nonprofit firefighting corporation, other political subdivision of
362.20 this or another state, another state, federally recognized Indian tribe, the University
362.21 of Minnesota, the Minnesota Historical Society, nonprofit hospitals licensed under
362.22 sections 144.50 to 144.56, rehabilitation facilities and extended employment providers
362.23 that are certified by the commissioner of employment and economic development, ~~day~~
362.24 ~~training and habilitation services licensed under sections 245B.01 to 245B.08,~~ day and
362.25 supported employment services licensed under chapter 245D, and any agency of the state
362.26 of Minnesota or the United States, and includes any instrumentality of a governmental
362.27 unit. For the purpose of this section, an instrumentality of a governmental unit means an
362.28 instrumentality having independent policy-making and appropriating authority.

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

362.30 Sec. 13. Minnesota Statutes 2012, section 626.556, subdivision 2, is amended to read:
362.31 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
362.32 given them unless the specific content indicates otherwise:

363.1 (a) "Family assessment" means a comprehensive assessment of child safety, risk
363.2 of subsequent child maltreatment, and family strengths and needs that is applied to a
363.3 child maltreatment report that does not allege substantial child endangerment. Family
363.4 assessment does not include a determination as to whether child maltreatment occurred
363.5 but does determine the need for services to address the safety of family members and the
363.6 risk of subsequent maltreatment.

363.7 (b) "Investigation" means fact gathering related to the current safety of a child
363.8 and the risk of subsequent maltreatment that determines whether child maltreatment
363.9 occurred and whether child protective services are needed. An investigation must be used
363.10 when reports involve substantial child endangerment, and for reports of maltreatment in
363.11 facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to
363.12 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and
363.13 13, and 124D.10; or in a nonlicensed personal care provider association as defined in
363.14 sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

363.15 (c) "Substantial child endangerment" means a person responsible for a child's care,
363.16 and in the case of sexual abuse includes a person who has a significant relationship to the
363.17 child as defined in section 609.341, or a person in a position of authority as defined in
363.18 section 609.341, who by act or omission commits or attempts to commit an act against a
363.19 child under their care that constitutes any of the following:

363.20 (1) egregious harm as defined in section 260C.007, subdivision 14;

363.21 (2) sexual abuse as defined in paragraph (d);

363.22 (3) abandonment under section 260C.301, subdivision 2;

363.23 (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the
363.24 child's physical or mental health, including a growth delay, which may be referred to as
363.25 failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

363.26 (5) murder in the first, second, or third degree under section 609.185, 609.19, or
363.27 609.195;

363.28 (6) manslaughter in the first or second degree under section 609.20 or 609.205;

363.29 (7) assault in the first, second, or third degree under section 609.221, 609.222, or
363.30 609.223;

363.31 (8) solicitation, inducement, and promotion of prostitution under section 609.322;

363.32 (9) criminal sexual conduct under sections 609.342 to 609.3451;

363.33 (10) solicitation of children to engage in sexual conduct under section 609.352;

363.34 (11) malicious punishment or neglect or endangerment of a child under section
363.35 609.377 or 609.378;

363.36 (12) use of a minor in sexual performance under section 617.246; or

364.1 (13) parental behavior, status, or condition which mandates that the county attorney
364.2 file a termination of parental rights petition under section 260C.301, subdivision 3,
364.3 paragraph (a).

364.4 (d) "Sexual abuse" means the subjection of a child by a person responsible for the
364.5 child's care, by a person who has a significant relationship to the child, as defined in
364.6 section 609.341, or by a person in a position of authority, as defined in section 609.341,
364.7 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual
364.8 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),
364.9 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct
364.10 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual
364.11 abuse also includes any act which involves a minor which constitutes a violation of
364.12 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes
364.13 threatened sexual abuse which includes the status of a parent or household member
364.14 who has committed a violation which requires registration as an offender under section
364.15 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section
364.16 243.166, subdivision 1b, paragraph (a) or (b).

364.17 (e) "Person responsible for the child's care" means (1) an individual functioning
364.18 within the family unit and having responsibilities for the care of the child such as a
364.19 parent, guardian, or other person having similar care responsibilities, or (2) an individual
364.20 functioning outside the family unit and having responsibilities for the care of the child
364.21 such as a teacher, school administrator, other school employees or agents, or other lawful
364.22 custodian of a child having either full-time or short-term care responsibilities including,
364.23 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
364.24 and coaching.

364.25 (f) "Neglect" means the commission or omission of any of the acts specified under
364.26 clauses (1) to (9), other than by accidental means:

364.27 (1) failure by a person responsible for a child's care to supply a child with necessary
364.28 food, clothing, shelter, health, medical, or other care required for the child's physical or
364.29 mental health when reasonably able to do so;

364.30 (2) failure to protect a child from conditions or actions that seriously endanger the
364.31 child's physical or mental health when reasonably able to do so, including a growth delay,
364.32 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
364.33 is due to parental neglect;

364.34 (3) failure to provide for necessary supervision or child care arrangements
364.35 appropriate for a child after considering factors as the child's age, mental ability, physical

365.1 condition, length of absence, or environment, when the child is unable to care for the
365.2 child's own basic needs or safety, or the basic needs or safety of another child in their care;

365.3 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
365.4 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
365.5 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

365.6 (5) nothing in this section shall be construed to mean that a child is neglected solely
365.7 because the child's parent, guardian, or other person responsible for the child's care in
365.8 good faith selects and depends upon spiritual means or prayer for treatment or care of
365.9 disease or remedial care of the child in lieu of medical care; except that a parent, guardian,
365.10 or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report
365.11 if a lack of medical care may cause serious danger to the child's health. This section does
365.12 not impose upon persons, not otherwise legally responsible for providing a child with
365.13 necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

365.14 (6) prenatal exposure to a controlled substance, as defined in section 253B.02,
365.15 subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal
365.16 symptoms in the child at birth, results of a toxicology test performed on the mother at
365.17 delivery or the child at birth, medical effects or developmental delays during the child's
365.18 first year of life that medically indicate prenatal exposure to a controlled substance, or the
365.19 presence of a fetal alcohol spectrum disorder;

365.20 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

365.21 (8) chronic and severe use of alcohol or a controlled substance by a parent or
365.22 person responsible for the care of the child that adversely affects the child's basic needs
365.23 and safety; or

365.24 (9) emotional harm from a pattern of behavior which contributes to impaired
365.25 emotional functioning of the child which may be demonstrated by a substantial and
365.26 observable effect in the child's behavior, emotional response, or cognition that is not
365.27 within the normal range for the child's age and stage of development, with due regard to
365.28 the child's culture.

365.29 (g) "Physical abuse" means any physical injury, mental injury, or threatened injury,
365.30 inflicted by a person responsible for the child's care on a child other than by accidental
365.31 means, or any physical or mental injury that cannot reasonably be explained by the child's
365.32 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
365.33 that have not been authorized under section 121A.67 or 245.825.

365.34 Abuse does not include reasonable and moderate physical discipline of a child
365.35 administered by a parent or legal guardian which does not result in an injury. Abuse does
365.36 not include the use of reasonable force by a teacher, principal, or school employee as

366.1 allowed by section 121A.582. Actions which are not reasonable and moderate include,
366.2 but are not limited to, any of the following that are done in anger or without regard to the
366.3 safety of the child:

366.4 (1) throwing, kicking, burning, biting, or cutting a child;

366.5 (2) striking a child with a closed fist;

366.6 (3) shaking a child under age three;

366.7 (4) striking or other actions which result in any nonaccidental injury to a child
366.8 under 18 months of age;

366.9 (5) unreasonable interference with a child's breathing;

366.10 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

366.11 (7) striking a child under age one on the face or head;

366.12 (8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
366.13 substances which were not prescribed for the child by a practitioner, in order to control or
366.14 punish the child; or other substances that substantially affect the child's behavior, motor
366.15 coordination, or judgment or that results in sickness or internal injury, or subjects the
366.16 child to medical procedures that would be unnecessary if the child were not exposed
366.17 to the substances;

366.18 (9) unreasonable physical confinement or restraint not permitted under section
366.19 609.379, including but not limited to tying, caging, or chaining; or

366.20 (10) in a school facility or school zone, an act by a person responsible for the child's
366.21 care that is a violation under section 121A.58.

366.22 (h) "Report" means any report received by the local welfare agency, police
366.23 department, county sheriff, or agency responsible for assessing or investigating
366.24 maltreatment pursuant to this section.

366.25 (i) "Facility" means:

366.26 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
366.27 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
366.28 144.58, 241.021, or 245A.01 to 245A.16, or chapter ~~245B~~ 245D;

366.29 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
366.30 124D.10; or

366.31 (3) a nonlicensed personal care provider organization as defined in sections 256B.04,
366.32 subdivision 16, and 256B.0625, subdivision 19a.

366.33 (j) "Operator" means an operator or agency as defined in section 245A.02.

366.34 (k) "Commissioner" means the commissioner of human services.

367.1 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
367.2 not limited to employee assistance counseling and the provision of guardian ad litem and
367.3 parenting time expeditor services.

367.4 (m) "Mental injury" means an injury to the psychological capacity or emotional
367.5 stability of a child as evidenced by an observable or substantial impairment in the child's
367.6 ability to function within a normal range of performance and behavior with due regard to
367.7 the child's culture.

367.8 (n) "Threatened injury" means a statement, overt act, condition, or status that
367.9 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
367.10 injury includes, but is not limited to, exposing a child to a person responsible for the
367.11 child's care, as defined in paragraph (e), clause (1), who has:

367.12 (1) subjected a child to, or failed to protect a child from, an overt act or condition
367.13 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
367.14 similar law of another jurisdiction;

367.15 (2) been found to be palpably unfit under section 260C.301, paragraph (b), clause
367.16 (4), or a similar law of another jurisdiction;

367.17 (3) committed an act that has resulted in an involuntary termination of parental rights
367.18 under section 260C.301, or a similar law of another jurisdiction; or

367.19 (4) committed an act that has resulted in the involuntary transfer of permanent
367.20 legal and physical custody of a child to a relative under Minnesota Statutes 2010, section
367.21 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a
367.22 similar law of another jurisdiction.

367.23 A child is the subject of a report of threatened injury when the responsible social
367.24 services agency receives birth match data under paragraph (o) from the Department of
367.25 Human Services.

367.26 (o) Upon receiving data under section 144.225, subdivision 2b, contained in a
367.27 birth record or recognition of parentage identifying a child who is subject to threatened
367.28 injury under paragraph (n), the Department of Human Services shall send the data to the
367.29 responsible social services agency. The data is known as "birth match" data. Unless the
367.30 responsible social services agency has already begun an investigation or assessment of the
367.31 report due to the birth of the child or execution of the recognition of parentage and the
367.32 parent's previous history with child protection, the agency shall accept the birth match
367.33 data as a report under this section. The agency may use either a family assessment or
367.34 investigation to determine whether the child is safe. All of the provisions of this section
367.35 apply. If the child is determined to be safe, the agency shall consult with the county
367.36 attorney to determine the appropriateness of filing a petition alleging the child is in need

368.1 of protection or services under section 260C.007, subdivision 6, clause (16), in order to
368.2 deliver needed services. If the child is determined not to be safe, the agency and the county
368.3 attorney shall take appropriate action as required under section 260C.301, subdivision 3.

368.4 (p) Persons who conduct assessments or investigations under this section shall take
368.5 into account accepted child-rearing practices of the culture in which a child participates
368.6 and accepted teacher discipline practices, which are not injurious to the child's health,
368.7 welfare, and safety.

368.8 (q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected
368.9 occurrence or event which:

368.10 (1) is not likely to occur and could not have been prevented by exercise of due
368.11 care; and

368.12 (2) if occurring while a child is receiving services from a facility, happens when the
368.13 facility and the employee or person providing services in the facility are in compliance
368.14 with the laws and rules relevant to the occurrence or event.

368.15 (r) "Nonmaltreatment mistake" means:

368.16 (1) at the time of the incident, the individual was performing duties identified in the
368.17 center's child care program plan required under Minnesota Rules, part 9503.0045;

368.18 (2) the individual has not been determined responsible for a similar incident that
368.19 resulted in a finding of maltreatment for at least seven years;

368.20 (3) the individual has not been determined to have committed a similar
368.21 nonmaltreatment mistake under this paragraph for at least four years;

368.22 (4) any injury to a child resulting from the incident, if treated, is treated only with
368.23 remedies that are available over the counter, whether ordered by a medical professional or
368.24 not; and

368.25 (5) except for the period when the incident occurred, the facility and the individual
368.26 providing services were both in compliance with all licensing requirements relevant to the
368.27 incident.

368.28 This definition only applies to child care centers licensed under Minnesota
368.29 Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of
368.30 substantiated maltreatment by the individual, the commissioner of human services shall
368.31 determine that a nonmaltreatment mistake was made by the individual.

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

368.33 Sec. 14. Minnesota Statutes 2012, section 626.556, subdivision 3, is amended to read:

368.34 Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason
368.35 to believe a child is being neglected or physically or sexually abused, as defined in

369.1 subdivision 2, or has been neglected or physically or sexually abused within the preceding
369.2 three years, shall immediately report the information to the local welfare agency, agency
369.3 responsible for assessing or investigating the report, police department, or the county
369.4 sheriff if the person is:
369.5 (1) a professional or professional's delegate who is engaged in the practice of
369.6 the healing arts, social services, hospital administration, psychological or psychiatric
369.7 treatment, child care, education, correctional supervision, probation and correctional
369.8 services, or law enforcement; or
369.9 (2) employed as a member of the clergy and received the information while
369.10 engaged in ministerial duties, provided that a member of the clergy is not required by
369.11 this subdivision to report information that is otherwise privileged under section 595.02,
369.12 subdivision 1, paragraph (c).
369.13 The police department or the county sheriff, upon receiving a report, shall
369.14 immediately notify the local welfare agency or agency responsible for assessing or
369.15 investigating the report, orally and in writing. The local welfare agency, or agency
369.16 responsible for assessing or investigating the report, upon receiving a report, shall
369.17 immediately notify the local police department or the county sheriff orally and in writing.
369.18 The county sheriff and the head of every local welfare agency, agency responsible
369.19 for assessing or investigating reports, and police department shall each designate a
369.20 person within their agency, department, or office who is responsible for ensuring that
369.21 the notification duties of this paragraph and paragraph (b) are carried out. Nothing in
369.22 this subdivision shall be construed to require more than one report from any institution,
369.23 facility, school, or agency.
369.24 (b) Any person may voluntarily report to the local welfare agency, agency responsible
369.25 for assessing or investigating the report, police department, or the county sheriff if the
369.26 person knows, has reason to believe, or suspects a child is being or has been neglected or
369.27 subjected to physical or sexual abuse. The police department or the county sheriff, upon
369.28 receiving a report, shall immediately notify the local welfare agency or agency responsible
369.29 for assessing or investigating the report, orally and in writing. The local welfare agency or
369.30 agency responsible for assessing or investigating the report, upon receiving a report, shall
369.31 immediately notify the local police department or the county sheriff orally and in writing.
369.32 (c) A person mandated to report physical or sexual child abuse or neglect occurring
369.33 within a licensed facility shall report the information to the agency responsible for
369.34 licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or
369.35 chapter ~~245B~~ 245D; or a nonlicensed personal care provider organization as defined in
369.36 sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections

370.1 agency receiving a report may request the local welfare agency to provide assistance
370.2 pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees
370.3 perform work within a school facility, upon receiving a complaint of alleged maltreatment,
370.4 shall provide information about the circumstances of the alleged maltreatment to the
370.5 commissioner of education. Section 13.03, subdivision 4, applies to data received by the
370.6 commissioner of education from a licensing entity.

370.7 (d) Any person mandated to report shall receive a summary of the disposition of
370.8 any report made by that reporter, including whether the case has been opened for child
370.9 protection or other services, or if a referral has been made to a community organization,
370.10 unless release would be detrimental to the best interests of the child. Any person who is
370.11 not mandated to report shall, upon request to the local welfare agency, receive a concise
370.12 summary of the disposition of any report made by that reporter, unless release would be
370.13 detrimental to the best interests of the child.

370.14 (e) For purposes of this section, "immediately" means as soon as possible but in
370.15 no event longer than 24 hours.

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

370.17 Sec. 15. Minnesota Statutes 2012, section 626.556, subdivision 10d, is amended to read:

370.18 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is
370.19 received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while
370.20 in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
370.21 sanitarium, or other facility or institution required to be licensed according to sections
370.22 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter ~~245B~~ 245D, or a school as
370.23 defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed
370.24 personal care provider organization as defined in section 256B.04, subdivision 16, and
370.25 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing
370.26 or investigating the report or local welfare agency investigating the report shall provide
370.27 the following information to the parent, guardian, or legal custodian of a child alleged to
370.28 have been neglected, physically abused, sexually abused, or the victim of maltreatment
370.29 of a child in the facility: the name of the facility; the fact that a report alleging neglect,
370.30 physical abuse, sexual abuse, or maltreatment of a child in the facility has been received;
370.31 the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child
370.32 in the facility; that the agency is conducting an assessment or investigation; any protective
370.33 or corrective measures being taken pending the outcome of the investigation; and that a
370.34 written memorandum will be provided when the investigation is completed.

371.1 (b) The commissioner of the agency responsible for assessing or investigating the
371.2 report or local welfare agency may also provide the information in paragraph (a) to the
371.3 parent, guardian, or legal custodian of any other child in the facility if the investigative
371.4 agency knows or has reason to believe the alleged neglect, physical abuse, sexual
371.5 abuse, or maltreatment of a child in the facility has occurred. In determining whether
371.6 to exercise this authority, the commissioner of the agency responsible for assessing
371.7 or investigating the report or local welfare agency shall consider the seriousness of the
371.8 alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the
371.9 number of children allegedly neglected, physically abused, sexually abused, or victims of
371.10 maltreatment of a child in the facility; the number of alleged perpetrators; and the length
371.11 of the investigation. The facility shall be notified whenever this discretion is exercised.
371.12 (c) When the commissioner of the agency responsible for assessing or investigating
371.13 the report or local welfare agency has completed its investigation, every parent, guardian,
371.14 or legal custodian previously notified of the investigation by the commissioner or
371.15 local welfare agency shall be provided with the following information in a written
371.16 memorandum: the name of the facility investigated; the nature of the alleged neglect,
371.17 physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's
371.18 name; a summary of the investigation findings; a statement whether maltreatment was
371.19 found; and the protective or corrective measures that are being or will be taken. The
371.20 memorandum shall be written in a manner that protects the identity of the reporter and
371.21 the child and shall not contain the name, or to the extent possible, reveal the identity of
371.22 the alleged perpetrator or of those interviewed during the investigation. If maltreatment
371.23 is determined to exist, the commissioner or local welfare agency shall also provide the
371.24 written memorandum to the parent, guardian, or legal custodian of each child in the facility
371.25 who had contact with the individual responsible for the maltreatment. When the facility is
371.26 the responsible party for maltreatment, the commissioner or local welfare agency shall also
371.27 provide the written memorandum to the parent, guardian, or legal custodian of each child
371.28 who received services in the population of the facility where the maltreatment occurred.
371.29 This notification must be provided to the parent, guardian, or legal custodian of each child
371.30 receiving services from the time the maltreatment occurred until either the individual
371.31 responsible for maltreatment is no longer in contact with a child or children in the facility
371.32 or the conclusion of the investigation. In the case of maltreatment within a school facility,
371.33 as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10, the commissioner
371.34 of education need not provide notification to parents, guardians, or legal custodians of
371.35 each child in the facility, but shall, within ten days after the investigation is completed,
371.36 provide written notification to the parent, guardian, or legal custodian of any student

372.1 alleged to have been maltreated. The commissioner of education may notify the parent,
372.2 guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

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

372.4 Sec. 16. **REPEALER.**

372.5 Minnesota Statutes 2012, section 256B.49, subdivision 16a, is repealed effective
372.6 January 1, 2014.

372.7 **ARTICLE 11**

372.8 **MISCELLANEOUS**

372.9 Section 1. Minnesota Statutes 2012, section 246.54, is amended to read:

372.10 **246.54 LIABILITY OF COUNTY; REIMBURSEMENT.**

372.11 Subdivision 1. **County portion for cost of care.** (a) Except for chemical
372.12 dependency services provided under sections 254B.01 to 254B.09, the client's county
372.13 shall pay to the state of Minnesota a portion of the cost of care provided in a regional
372.14 treatment center or a state nursing facility to a client legally settled in that county. A
372.15 county's payment shall be made from the county's own sources of revenue and payments
372.16 shall equal a percentage of the cost of care, as determined by the commissioner, for each
372.17 day, or the portion thereof, that the client spends at a regional treatment center or a state
372.18 nursing facility according to the following schedule:

372.19 (1) zero percent for the first 30 days;

372.20 (2) 20 percent for days 31 to 60; and

372.21 (3) ~~50~~ 75 percent for any days over 60.

372.22 (b) The increase in the county portion for cost of care under paragraph (a), clause
372.23 (3), shall be imposed when the treatment facility has determined that it is clinically
372.24 appropriate for the client to be discharged.

372.25 (c) If payments received by the state under sections 246.50 to 246.53 exceed 80
372.26 percent of the cost of care for days 31 to 60, or ~~50~~ 25 percent for days over 60, the county
372.27 shall be responsible for paying the state only the remaining amount. The county shall
372.28 not be entitled to reimbursement from the client, the client's estate, or from the client's
372.29 relatives, except as provided in section 246.53.

372.30 Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the
372.31 Minnesota Security Hospital ~~or the Minnesota extended treatment options program~~. For
372.32 services at ~~these facilities~~ the Minnesota Security Hospital, a county's payment shall be
372.33 made from the county's own sources of revenue and payments ~~shall be paid as follows:~~.

373.1 Excluding the state-operated forensic transition service, payments to the state from the
373.2 county shall equal ten percent of the cost of care, as determined by the commissioner, for
373.3 each day, or the portion thereof, that the client spends at the facility. For the state-operated
373.4 forensic transition service, payments to the state from the county shall equal 50 percent of
373.5 the cost of care, as determined by the commissioner, for each day, or the portion thereof,
373.6 that the client spends in the program. If payments received by the state under sections
373.7 246.50 to 246.53 for services provided at the Minnesota Security Hospital, excluding the
373.8 state-operated forensic transition service, exceed 90 percent of the cost of care, the county
373.9 shall be responsible for paying the state only the remaining amount. If payments received
373.10 by the state under sections 246.50 to 246.53 for the state-operated forensic transition service
373.11 exceed 50 percent of the cost of care, the county shall be responsible for paying the state
373.12 only the remaining amount. The county shall not be entitled to reimbursement from the
373.13 client, the client's estate, or from the client's relatives, except as provided in section 246.53.

373.14 (b) Regardless of the facility to which the client is committed, subdivision 1 does
373.15 not apply to the following individuals:

373.16 ~~(1) clients who are committed as mentally ill and dangerous under section 253B.02,~~
373.17 ~~subdivision 17;~~

373.18 ~~(2)~~ (1) clients who are committed as sexual psychopathic personalities under section
373.19 253B.02, subdivision 18b; and

373.20 ~~(3)~~ (2) clients who are committed as sexually dangerous persons under section
373.21 253B.02, subdivision 18c.

373.22 ~~For each of the individuals in clauses (1) to (3), the payment by the county to the state~~
373.23 ~~shall equal ten percent of the cost of care for each day as determined by the commissioner.~~

373.24 Sec. 2. Minnesota Statutes 2012, section 402A.10, is amended to read:

373.25 **402A.10 DEFINITIONS.**

373.26 Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined
373.27 in this section have the meanings given.

373.28 Subd. 1a. **Balanced set of program measures.** A "balanced set of program
373.29 measures" is a set of measures that, together, adequately quantify achievement toward a
373.30 particular program's outcome. As directed by section 402A.16, the Human Services
373.31 Performance Council must recommend to the commissioner when a particular program
373.32 has a balanced set of program measures.

373.33 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human
373.34 services.

374.1 Subd. 3. **Council.** "Council" means the State-County Results, Accountability, and
374.2 Service Delivery Redesign Council established in section 402A.20.
374.3 Subd. 4. **Essential human services or essential services.** "Essential human
374.4 services" or "essential services" means assistance and services to recipients or potential
374.5 recipients of public welfare and other services delivered by counties or tribes that are
374.6 mandated in federal and state law that are to be available in all counties of the state.
374.7 Subd. 4a. **Essential human services program.** An "essential human services
374.8 program" for the purposes of remedies under section 402A.18 means the following
374.9 programs:
374.10 (1) child welfare, including protection, truancy, minor parent, guardianship, and
374.11 adoption;
374.12 (2) children's mental health;
374.13 (3) children's disability services;
374.14 (4) public assistance eligibility, including measures related to processing timelines
374.15 across information services programs;
374.16 (5) MFIP;
374.17 (6) child support;
374.18 (7) chemical dependency;
374.19 (8) adult disability;
374.20 (9) adult mental health;
374.21 (10) adult services such as long-term care; and
374.22 (11) adult protection.
374.23 Subd. 4b. **Measure.** A "measure" means a quantitative indicator of a performance
374.24 outcome.
374.25 Subd. 4c. **Performance improvement plan.** A "performance improvement plan"
374.26 means a plan developed by a county or service delivery authority that describes steps the
374.27 county or service delivery authority must take to improve performance on a specific
374.28 measure or set of measures. The performance improvement plan must be negotiated
374.29 with and approved by the commissioner. The performance improvement plan must
374.30 require a specific numerical improvement in the measure or measures on which the plan
374.31 is based and may include specific programmatic best practices or specific performance
374.32 management practices that the county must implement.
374.33 Subd. 4d. **Performance management system for human services.** A "performance
374.34 management system for human services" means a process by which performance data for
374.35 essential human services is collected from counties or service delivery authorities and used
374.36 to inform a variety of stakeholders and to improve performance over time.

375.1 Subd. 5. **Service delivery authority.** "Service delivery authority" means a single
375.2 county, or consortium of counties operating by execution of a joint powers agreement
375.3 under section 471.59 or other contractual agreement, that has voluntarily chosen by
375.4 resolution of the county board of commissioners to participate in the redesign under this
375.5 chapter or has been assigned by the commissioner pursuant to section 402A.18. A service
375.6 delivery authority includes an Indian tribe or group of tribes that have voluntarily chosen
375.7 by resolution of tribal government to participate in redesign under this chapter.

375.8 Subd. 6. **Steering committee.** "Steering committee" means the Steering Committee
375.9 on Performance and Outcome Reforms.

375.10 Sec. 3. **[402A.12] ESTABLISHMENT OF A PERFORMANCE MANAGEMENT**
375.11 **SYSTEM FOR HUMAN SERVICES.**

375.12 By January 1, 2014, the commissioner shall implement a performance management
375.13 system for essential human services as described in sections 402A.15 to 402A.18 that
375.14 includes initial performance measures and standards consistent with the recommendations
375.15 of the Steering Committee on Performance and Outcome Reforms in the December 2012
375.16 report to the legislature.

375.17 Sec. 4. **[402A.16] HUMAN SERVICES PERFORMANCE COUNCIL.**

375.18 Subdivision 1. **Establishment.** By October 1, 2013, the commissioner shall convene
375.19 a Human Services Performance Council to advise the commissioner on the implementation
375.20 and operation of the performance management system for human services.

375.21 Subd. 2. **Duties.** The Human Services Performance Council shall:

375.22 (1) hold meetings at least quarterly that are in compliance with Minnesota's Open
375.23 Meeting Law under chapter 13D;

375.24 (2) annually review the annual performance data submitted by counties or service
375.25 delivery authorities;

375.26 (3) review and advise the commissioner on department procedures related to the
375.27 implementation of the performance management system and system process requirements
375.28 and on barriers to process improvement in human services delivery;

375.29 (4) advise the commissioner on the training and technical assistance needs of county
375.30 or service delivery authority and department personnel;

375.31 (5) review instances in which a county or service delivery authority has not made
375.32 adequate progress on a performance improvement plan and make recommendations to
375.33 the commissioner under section 402A.18;

376.1 (6) consider appeals from counties or service delivery authorities that are in the
376.2 remedies process and make recommendations to the commissioner on resolving the issue;
376.3 (7) convene working groups to update and develop outcomes, measures, and
376.4 performance standards for the performance management system and, on an annual basis,
376.5 present these recommendations to the commissioner, including recommendations on when
376.6 a particular essential human service program has a balanced set of program measures
376.7 in place;
376.8 (8) make recommendations on human services administrative rules or statutes that
376.9 could be repealed in order to improve service delivery;
376.10 (9) provide information to stakeholders on the council's role and regularly collect
376.11 stakeholder input on performance management system performance; and
376.12 (10) submit an annual report to the legislature and the commissioner, which
376.13 includes a comprehensive report on the performance of individual counties or service
376.14 delivery authorities as it relates to system measures; a list of counties or service delivery
376.15 authorities that have been required to create performance improvement plans and the areas
376.16 identified for improvement as part of the remedies process; a summary of performance
376.17 improvement training and technical assistance activities offered to the county personnel
376.18 by the department; recommendations on administrative rules or state statutes that could be
376.19 repealed in order to improve service delivery; recommendations for system improvements,
376.20 including updates to system outcomes, measures and standards; and a response from
376.21 the commissioner.
376.22 Subd. 3. **Membership.** (a) Human Services Performance Council membership shall
376.23 be equally balanced among the following five stakeholder groups: the Association of
376.24 Minnesota Counties, the Minnesota Association of County Social Service Administrators,
376.25 the Department of Human Services, tribes and communities of color, and service providers
376.26 and advocates for persons receiving human services. The Association of Minnesota
376.27 Counties and the Minnesota Association of County Social Service Administrators shall
376.28 appoint their own respective representatives. The commissioner of human services shall
376.29 appoint representatives of the Department of Human Services, tribes and communities of
376.30 color, and social services providers and advocates. Minimum council membership shall
376.31 be 15 members, with at least three representatives from each stakeholder group, and
376.32 maximum council membership shall be 20 members, with four representatives from
376.33 each stakeholder group.
376.34 (b) Notwithstanding section 15.059, Human Services Performance Council members
376.35 shall be appointed for a minimum of two years, but may serve longer terms at the
376.36 discretion of their appointing authority.

377.1 (c) Notwithstanding section 15.059, members of the council shall receive no
377.2 compensation for their services.
377.3 (d) A commissioner's representative and a county representative from either the
377.4 Association of Minnesota Counties or the Minnesota Association of County Social Service
377.5 Administrators shall serve as Human Services Performance Council cochairs.
377.6 Subd. 4. **Commissioner duties.** The commissioner shall:
377.7 (1) implement and maintain the performance management system for human services;
377.8 (2) establish and regularly update the system's outcomes, measures, and standards,
377.9 including the minimum performance standard for each performance measure;
377.10 (3) determine when a particular program has a balanced set of measures;
377.11 (4) receive reports from counties or service delivery authorities at least annually on
377.12 their performance against system measures, provide counties with data needed to assess
377.13 performance and monitor progress, and provide timely feedback to counties or service
377.14 delivery authorities on their performance;
377.15 (5) implement and monitor the remedies process in section 402A.18;
377.16 (6) report to the Human Services Performance Council on county or service delivery
377.17 authority performance on a semiannual basis;
377.18 (7) provide general training and technical assistance to counties or service delivery
377.19 authorities on topics related to performance measurement and performance improvement;
377.20 (8) provide targeted training and technical assistance to counties or service delivery
377.21 authorities that supports their performance improvement plans; and
377.22 (9) provide staff support for the Human Services Performance Council.
377.23 Subd. 5. **County or service delivery authority duties.** The counties or service
377.24 delivery authorities shall:
377.25 (1) report performance data to meet performance management system requirements;
377.26 and
377.27 (2) provide training to personnel on basic principles of performance measurement
377.28 and improvement and participate in training provided by the department.

377.29 Sec. 5. Minnesota Statutes 2012, section 402A.18, is amended to read:
377.30 **402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET**
377.31 **PERFORMANCE OUTCOMES.**
377.32 Subdivision 1. **Underperforming county; specific service.** If the commissioner
377.33 determines that a county or service delivery authority is deficient in achieving minimum
377.34 performance ~~outcomes~~ standards for a specific essential ~~service~~ human services program,

the commissioner may impose the following remedies and adjust state and federal program allocations accordingly:

(1) voluntary incorporation of the administration and operation of the specific essential ~~service~~ human services program with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of the specific essential ~~service~~ human services program with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of the specific essential ~~service~~ human services program to the commissioner.

Subd. 2. **Underperforming county; more than one-half of services.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance ~~outcomes~~ standards for more than one-half of the defined essential human services programs, the commissioner may impose the following remedies:

(1) voluntary incorporation of the administration and operation of essential human services programs with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of essential human services programs with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for ~~program~~ administration and operation of essential human services programs to the commissioner.

Subd. 2a. **Financial responsibility of underperforming county.** A county subject to remedies under subdivision 1 or 2 shall provide to the entity assuming administration of the ~~essential service or~~ essential human services program or programs the amount of nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

Subd. 3. **Conditions prior to imposing remedies.** ~~Before the commissioner may impose the remedies authorized under this section, the following conditions must be met:~~

379.1 ~~(1) the county or service delivery authority determined by the commissioner~~
379.2 ~~to be deficient in achieving minimum performance outcomes has the opportunity, in~~
379.3 ~~coordination with the council, to develop a program outcome improvement plan. The~~
379.4 ~~program outcome improvement plan must be developed no later than six months from the~~
379.5 ~~date of the deficiency determination; and~~
379.6 ~~(2) the council has conducted an assessment of the program outcome improvement~~
379.7 ~~plan to determine if the county or service delivery authority has made satisfactory progress~~
379.8 ~~toward performance outcomes and has made a recommendation about remedies to the~~
379.9 ~~commissioner. The assessment and recommendation must be made to the commissioner~~
379.10 ~~within 12 months from the date of the deficiency determination.~~ (a) The commissioner
379.11 shall notify a county or service delivery authority that it must submit a performance
379.12 improvement plan if:
379.13 (1) the county or service delivery authority does not meet the minimum performance
379.14 standard for a measure; or
379.15 (2) the county or service delivery authority does not meet the minimum performance
379.16 standard for one or more racial or ethnic subgroup for which there is a statistically valid
379.17 population size for three or more measures, even if the county or service delivery authority
379.18 met the standard for the overall population.
379.19 The commissioner must approve the performance improvement plan. The county or
379.20 service delivery authority may negotiate the terms of the performance improvement plan
379.21 with the commissioner.
379.22 (b) When the department determines that a county or service delivery authority does
379.23 not meet the minimum performance standard for a given measure, the commissioner
379.24 must advise the county or service delivery authority that fiscal penalties may result if the
379.25 performance does not improve. The department must offer technical assistance to the
379.26 county or service delivery authority. Within 30 days of the initial advisement from the
379.27 department, the county or service delivery authority may claim and the department may
379.28 approve an extenuating circumstance that relieves the county or service delivery authority
379.29 of any further remedy. If a county or service delivery authority has a small number of
379.30 participants in an essential human services program such that reliable measurement is
379.31 not possible, the commissioner may approve extenuating circumstances or may average
379.32 performance over three years.
379.33 (c) If there are no extenuating circumstances, the county or service delivery authority
379.34 must submit a performance improvement plan to the commissioner within 60 days of the
379.35 initial advisement from the department. The term of the performance improvement plan
379.36 must be two years, starting with the date the plan is approved by the commissioner. This

380.1 plan must include a target level for improvement for each measure that did not meet
380.2 the minimum performance standard. The commissioner must approve the performance
380.3 improvement plan within 60 days of submittal.

380.4 (d) The department must monitor the performance improvement plan for two
380.5 years. After two years, if the county or service delivery authority meets the minimum
380.6 performance standard, there is no further remedy. If the county or service delivery
380.7 authority fails to meet the minimum performance standard, but meets the improvement
380.8 target in the performance improvement plan, the county or service delivery authority shall
380.9 modify the performance improvement plan for further improvement and the department
380.10 shall continue to monitor the plan.

380.11 (e) If, after two years of monitoring, the county or service delivery authority fails to
380.12 meet both the minimum performance standard and the improvement target identified in
380.13 the performance improvement plan, the next step of the remedies process shall be invoked
380.14 by the commissioner. This phase of the remedies process may include:

380.15 (1) fiscal penalties for the county or service delivery authority that do not exceed
380.16 one percent of the county's human services expenditures and that are negotiated in the
380.17 performance improvement plan, based on what is needed to improve outcomes. Counties
380.18 or service delivery authorities must reinvest the amount of the fiscal penalty into the
380.19 essential human services program that was underperforming. A county or service delivery
380.20 authority shall not be required to pay more than three fiscal penalties in a year; and

380.21 (2) the department's provision of technical assistance to the county or service
380.22 delivery authority that is targeted to address the specific performance issues.

380.23 The commissioner shall continue monitoring the performance improvement plan for a
380.24 third year.

380.25 (f) If, after the third year of monitoring, the county or service delivery authority
380.26 meets the minimum performance standard, there is no further remedy. If the county or
380.27 service delivery authority fails to meet the minimum performance standard, but meets the
380.28 improvement target for the performance improvement plan, the county or service delivery
380.29 authority shall modify the performance improvement plan for further improvement and
380.30 the department shall continue to monitor the plan.

380.31 (g) If, after the third year of monitoring, the county or service delivery authority fails
380.32 to meet the minimum performance standard and the improvement target identified in the
380.33 performance improvement plan, the Human Services Performance Council shall review
380.34 the situation and recommend a course of action to the commissioner.

380.35 (h) If the commissioner has determined that a program has a balanced set of program
380.36 measures and a county or service delivery authority is subject to fiscal penalties for more

381.1 than one-half of the measures for that program, the commissioner may apply further
381.2 remedies as described in subdivisions 1 and 2.

381.3 Sec. 6. Laws 1998, chapter 407, article 6, section 116, is amended to read:

381.4 Sec. 116. **EBT TRANSACTION COSTS; APPROVAL FROM LEGISLATURE.**

381.5 The commissioner of human services shall request and receive approval from the
381.6 legislature before adjusting the payment to not subsidize retailers for electronic benefit
381.7 transfer transaction costs Supplemental Nutrition Assistance Program transactions.

381.8 **EFFECTIVE DATE.** This section is effective 30 days after the commissioner
381.9 notifies retailers of the termination of their agreement with the state. The commissioner of
381.10 human services must notify the revisor of statutes of that date.

381.11 **ARTICLE 12**

381.12 **HOME CARE PROVIDERS**

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

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

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

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

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

381.24 (4) Social Security numbers; and

381.25 (5) health record data.

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

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

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

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

382.1 (3) correction orders, including information about compliance with the order and
382.2 whether the fine was paid;
382.3 (4) final enforcement actions pursuant to chapter 14;
382.4 (5) orders for hearing, findings of fact and conclusions of law; and
382.5 (6) when the licensee and department agree to resolve the matter without a hearing,
382.6 the agreement and specific reasons for the agreement are public data.

382.7 Sec. 3. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
382.8 to read:
382.9 Subd. 5. **Data classification; confidential data.** For providers regulated pursuant
382.10 to sections 144A.043 to 144A.482, the following data collected, created, or maintained
382.11 by the Department of Health are classified as "confidential data" as defined in section
382.12 13.02, subdivision 3: active investigative data relating to the investigation of potential
382.13 violations of law by licensee including data from the survey process before the correction
382.14 order is issued by the department.

382.15 Sec. 4. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
382.16 to read:
382.17 Subd. 6. **Release of private or confidential data.** For providers regulated pursuant
382.18 to sections 144A.043 to 144A.482, the department may release private or confidential
382.19 data, except Social Security numbers, to the appropriate state, federal, or local agency
382.20 and law enforcement office to enhance investigative or enforcement efforts or further
382.21 public health protective process. Types of offices include, but are not limited to, Adult
382.22 Protective Services, Office of the Ombudsmen for Long-Term Care and Office of the
382.23 Ombudsmen for Mental Health and Developmental Disabilities, the health licensing
382.24 boards, Department of Human Services, county or city attorney's offices, police, and local
382.25 or county public health offices.

382.26 Sec. 5. Minnesota Statutes 2012, section 144A.43, is amended to read:
382.27 **144A.43 DEFINITIONS.**
382.28 Subdivision 1. **Applicability.** The definitions in this section apply to sections
382.29 144.699, subdivision 2, and 144A.43 to ~~144A.47~~ 144A.482.
382.30 Subd. 1a. **Agent.** "Agent" means the person upon whom all notices and orders shall
382.31 be served and who is authorized to accept service of notices and orders on behalf of
382.32 the home care provider.

383.1 Subd. 1b. **Applicant.** "Applicant" means an individual, organization, association,
383.2 corporation, unit of government, or other entity that applies for a temporary license,
383.3 license, or renewal of their home care provider license under section 144A.472.

383.4 Subd. 1c. **Client.** "Client" means a person to whom home care services are provided.

383.5 Subd. 1d. **Client record.** "Client record" means all records that document
383.6 information about the home care services provided to the client by the home care provider.

383.7 Subd. 1e. **Client representative.** "Client representative" means a person who,
383.8 because of the client's needs, makes decisions about the client's care on behalf of the
383.9 client. A client representative may be a guardian, health care agent, family member, or
383.10 other agent of the client. Nothing in this section expands or diminishes the rights of
383.11 persons to act on behalf of clients under other law.

383.12 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

383.13 Subd. 2a. **Controlled substance.** "Controlled substance" has the meaning given
383.14 in section 152.01, subdivision 4.

383.15 Subd. 2b. **Department.** "Department" means the Minnesota Department of Health.

383.16 Subd. 2c. **Dietary supplement.** "Dietary supplement" means a product taken by
383.17 mouth that contains a "dietary ingredient" intended to supplement the diet. Dietary
383.18 ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and
383.19 substances such as enzymes, organ tissue, glandulars, or metabolites.

383.20 Subd. 2d. **Dietician.** "Dietitian" is a person licensed under sections 148.621 to
383.21 148.633.

383.22 Subd. 2e. **Dietetics or nutrition practice.** "Dietetics or nutrition practice" is
383.23 performed by a licensed dietician or licensed nutritionist and includes the activities of
383.24 assessment, setting priorities and objectives, providing nutrition counseling, developing
383.25 and implementing nutrition care services, and evaluating and maintaining appropriate
383.26 standards of quality of nutrition care under sections 148.621 to 148.633.

383.27 Subd. 3. **Home care service.** "Home care service" means any of the following
383.28 services ~~when~~ delivered in ~~a place of residence to~~ the home of a person whose illness,
383.29 disability, or physical condition creates a need for the service:

383.30 ~~(1) nursing services, including the services of a home health aide;~~

383.31 ~~(2) personal care services not included under sections 148.171 to 148.285;~~

383.32 ~~(3) physical therapy;~~

383.33 ~~(4) speech therapy;~~

383.34 ~~(5) respiratory therapy;~~

383.35 ~~(6) occupational therapy;~~

383.36 ~~(7) nutritional services;~~

384.1 ~~(8) home management services when provided to a person who is unable to perform~~
384.2 ~~these activities due to illness, disability, or physical condition. Home management~~
384.3 ~~services include at least two of the following services: housekeeping, meal preparation,~~
384.4 ~~and shopping;~~
384.5 ~~(9) medical social services;~~
384.6 ~~(10) the provision of medical supplies and equipment when accompanied by the~~
384.7 ~~provision of a home care service; and~~
384.8 ~~(11) other similar medical services and health-related support services identified by~~
384.9 ~~the commissioner in rule.~~
384.10 ~~"Home care service" does not include the following activities conducted by the~~
384.11 ~~commissioner of health or a board of health as defined in section 145A.02, subdivision 2:~~
384.12 ~~communicable disease investigations or testing; administering or monitoring a prescribed~~
384.13 ~~therapy necessary to control or prevent a communicable disease; or the monitoring~~
384.14 ~~of an individual's compliance with a health directive as defined in section 144.4172,~~
384.15 ~~subdivision 6.~~
384.16 (1) assistive tasks provided by unlicensed personnel;
384.17 (2) services provided by a registered nurse or licensed practical nurse, physical
384.18 therapist, respiratory therapist, occupational therapist, speech-language pathologist,
384.19 dietitian or nutritionist, or social worker;
384.20 (3) medication and treatment management services; or
384.21 (4) the provision of durable medical equipment services when provided with any of
384.22 the home care services listed in clauses (1) to (3).
384.23 Subd. 3a. **Hands-on-assistance.** "Hands-on-assistance" means physical help by
384.24 another person without which the client is not able to perform the activity.
384.25 Subd. 3b. **Home.** "Home" means the client's temporary or permanent place of
384.26 residence.
384.27 Subd. 4. **Home care provider.** "Home care provider" means an individual,
384.28 organization, association, corporation, unit of government, or other entity that is regularly
384.29 engaged in the delivery of at least one home care service, directly ~~or by contractual~~
384.30 ~~arrangement, of home care services~~ in a client's home for a fee and who has a valid current
384.31 temporary license or license issued under sections 144A.43 to 144A.482. ~~At least one~~
384.32 ~~home care service must be provided directly, although additional home care services may~~
384.33 ~~be provided by contractual arrangements. "Home care provider" does not include:~~
384.34 ~~(1) any home care or nursing services conducted by and for the adherents of any~~
384.35 ~~recognized church or religious denomination for the purpose of providing care and~~
384.36 ~~services for those who depend upon spiritual means, through prayer alone, for healing;~~

385.1 ~~(2) an individual who only provides services to a relative;~~
385.2 ~~(3) an individual not connected with a home care provider who provides assistance~~
385.3 ~~with home management services or personal care needs if the assistance is provided~~
385.4 ~~primarily as a contribution and not as a business;~~
385.5 ~~(4) an individual not connected with a home care provider who shares housing with~~
385.6 ~~and provides primarily housekeeping or homemaking services to an elderly or disabled~~
385.7 ~~person in return for free or reduced-cost housing;~~
385.8 ~~(5) an individual or agency providing home-delivered meal services;~~
385.9 ~~(6) an agency providing senior companion services and other older American~~
385.10 ~~volunteer programs established under the Domestic Volunteer Service Act of 1973,~~
385.11 ~~Public Law 98-288;~~
385.12 ~~(7) an employee of a nursing home licensed under this chapter or an employee of a~~
385.13 ~~boarding care home licensed under sections 144.50 to 144.56 who responds to occasional~~
385.14 ~~emergency calls from individuals residing in a residential setting that is attached to or~~
385.15 ~~located on property contiguous to the nursing home or boarding care home;~~
385.16 ~~(8) a member of a professional corporation organized under chapter 319B that does~~
385.17 ~~not regularly offer or provide home care services as defined in subdivision 3;~~
385.18 ~~(9) the following organizations established to provide medical or surgical services~~
385.19 ~~that do not regularly offer or provide home care services as defined in subdivision 3:~~
385.20 ~~a business trust organized under sections 318.01 to 318.04, a nonprofit corporation~~
385.21 ~~organized under chapter 317A, a partnership organized under chapter 323, or any other~~
385.22 ~~entity determined by the commissioner;~~
385.23 ~~(10) an individual or agency that provides medical supplies or durable medical~~
385.24 ~~equipment, except when the provision of supplies or equipment is accompanied by a~~
385.25 ~~home care service;~~
385.26 ~~(11) an individual licensed under chapter 147; or~~
385.27 ~~(12) an individual who provides home care services to a person with a developmental~~
385.28 ~~disability who lives in a place of residence with a family, foster family, or primary caregiver.~~
385.29 ~~Subd. 5.~~ ~~**Medication reminder.**~~ ~~"Medication reminder" means providing a verbal~~
385.30 ~~or visual reminder to a client to take medication. This includes bringing the medication~~
385.31 ~~to the client and providing liquids or nutrition to accompany medication that a client is~~
385.32 ~~self-administering.~~
385.33 Subd. 6. **License.** "License" means a basic or comprehensive home care license
385.34 issued by the commissioner to a home care provider.
385.35 Subd. 7. **Licensed health professional.** "Licensed health professional" means a
385.36 person, other than a registered nurse or licensed practical nurse, who provides home care

386.1 services within the scope of practice of the person's health occupation license, registration,
386.2 or certification as regulated and who is licensed by the appropriate Minnesota state board
386.3 or agency.

386.4 Subd. 8. **Licensee.** "Licensee" means a home care provider that is licensed under
386.5 this chapter.

386.6 Subd. 9. **Managerial official.** "Managerial official" means an administrator,
386.7 director, officer, trustee, or employee of a home care provider, however designated, who
386.8 has the authority to establish or control business policy.

386.9 Subd. 10. **Medication.** "Medication" means a prescription or over-the-counter drug.
386.10 For purposes of this chapter only, medication includes dietary supplements.

386.11 Subd. 11. **Medication administration.** "Medication administration" means
386.12 performing a set of tasks to ensure a client takes medications, and includes the following:

386.13 (1) checking the client's medication record;

386.14 (2) preparing the medication as necessary;

386.15 (3) administering the medication to the client;

386.16 (4) documenting the administration or reason for not administering the medication;
386.17 and

386.18 (5) reporting to a nurse any concerns about the medication, the client, or the client's
386.19 refusal to take the medication.

386.20 Subd. 12. **Medication management.** "Medication management" means the
386.21 provision of any of the following medication-related services to a client:

386.22 (1) performing medication setup;

386.23 (2) administering medication;

386.24 (3) storing and securing medications;

386.25 (4) documenting medication activities;

386.26 (5) verifying and monitoring effectiveness of systems to ensure safe handling and
386.27 administration;

386.28 (6) coordinating refills;

386.29 (7) handling and implementing changes to prescriptions;

386.30 (8) communicating with the pharmacy about the client's medications; and

386.31 (9) coordinating and communicating with the prescriber.

386.32 Subd. 13. **Medication setup.** "Medication setup" means arranging medications by a
386.33 nurse, pharmacy, or authorized prescriber for later administration by the client or by
386.34 comprehensive home care staff.

386.35 Subd. 14. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to
386.36 148.285.

387.1 Subd. 15. **Occupational therapist.** "Occupational therapist" means a person who is
387.2 licensed under sections 148.6401 to 148.6450.

387.3 Subd. 16. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is
387.4 not required by federal law to bear the symbol "Rx only."

387.5 Subd. 17. **Owner.** "Owner" means a proprietor, general partner, limited partner who
387.6 has five percent or more of equity interest in a limited partnership, a person who owns or
387.7 controls voting stock in a corporation in an amount equal to or greater than five percent of
387.8 the shares issued and outstanding, or a corporation that owns equity interest in a licensee
387.9 or applicant for a license.

387.10 Subd. 18. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01,
387.11 subdivision 3.

387.12 Subd. 19. **Physical therapist.** "Physical therapist" means a person who is licensed
387.13 under sections 148.65 to 148.78.

387.14 Subd. 20. **Physician.** "Physician" means a person who is licensed under chapter 147.

387.15 Subd. 21. **Prescriber.** "Prescriber" means a person who is authorized by sections
387.16 148.235; 151.01, subdivision 23; and 151.37, to prescribe prescription drugs.

387.17 Subd. 22. **Prescription.** "Prescription" has the meaning given in section 151.01,
387.18 subdivision 16.

387.19 Subd. 23. **Regularly scheduled.** "Regularly scheduled" means ordered or planned
387.20 to be completed at predetermined times or according to a predetermined routine.

387.21 Subd. 24. **Reminder.** "Reminder" means providing a verbal or visual reminder
387.22 to a client.

387.23 Subd. 25. **Respiratory therapist.** "Respiratory therapist" means a person who
387.24 is licensed under chapter 147C.

387.25 Subd. 26. **Revenues.** "Revenues" means all money or the value of property or
387.26 services received by a registrant and derived from the provision of home care services,
387.27 including fees for services, grants, bequests, gifts, donations, appropriations of public
387.28 money, and earned interest or dividends.

387.29 Subd. 27. **Service plan.** "Service plan" means the written plan between the client or
387.30 client's representative and the temporary licensee or licensee about the services that will
387.31 be provided to the client.

387.32 Subd. 28. **Social worker.** "Social worker" means a person who is licensed under
387.33 chapter 148D or 148E.

387.34 Subd. 29. **Speech language pathologist.** "Speech language pathologist" has the
387.35 meaning given in section 148.512.

388.1 Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another
388.2 person within arm's reach to minimize the risk of injury while performing daily activities
388.3 through physical intervention or cuing.

388.4 Subd. 31. **Substantial compliance.** "Substantial compliance" means complying
388.5 with the requirements in this chapter sufficiently to prevent unacceptable health or safety
388.6 risks to the home care client.

388.7 Subd. 32. **Survey.** "Survey" means an inspection of a licensee or applicant for
388.8 licensure for compliance with this chapter.

388.9 Subd. 33. **Surveyor.** "Surveyor" means a staff person of the department authorized
388.10 to conduct surveys of home care providers and applicants.

388.11 Subd. 34. **Temporary license.** "Temporary license" means the initial basic or
388.12 comprehensive home care license the department issues after approval of a complete
388.13 written application and before the department completes the temporary license survey and
388.14 determines that the temporary licensee is in substantial compliance.

388.15 Subd. 35. **Treatment or therapy.** "Treatment" or "therapy" means the provision
388.16 of care, other than medications, ordered or prescribed by a licensed health professional
388.17 provided to a client to cure, rehabilitate, or ease symptoms.

388.18 Subd. 36. **Unit of government.** "Unit of government" means every city, county,
388.19 town, school district, other political subdivisions of the state, and any agency of the state
388.20 or federal government, which includes any instrumentality of a unit of government.

388.21 Subd. 37. **Unlicensed personnel.** "Unlicensed personnel" are individuals not
388.22 otherwise licensed or certified by a governmental health board or agency who provide
388.23 home care services in the client's home.

388.24 Subd. 38. **Verbal.** "Verbal" means oral and not in writing.

388.25 Sec. 6. Minnesota Statutes 2012, section 144A.44, is amended to read:

388.26 **144A.44 HOME CARE BILL OF RIGHTS.**

388.27 Subdivision 1. **Statement of rights.** A person who receives home care services
388.28 has these rights:

388.29 (1) the right to receive written information about rights ~~in advance of~~ before
388.30 receiving ~~care or during the initial evaluation visit before the initiation of treatment~~
388.31 services, including what to do if rights are violated;

388.32 (2) the right to receive care and services according to a suitable and up-to-date plan,
388.33 and subject to accepted health care, medical or nursing standards, to take an active part
388.34 in ~~creating and changing the plan~~ developing, modifying, and evaluating ~~care~~ the plan
388.35 and services;

389.1 (3) the right to be told ~~in advance of~~ before receiving ~~care about the~~ services ~~that will~~
389.2 ~~be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will
389.3 be providing the services, the frequency of visits proposed to be furnished, other choices
389.4 that are available for addressing home care needs, and ~~the consequences of these choices~~
389.5 ~~including~~ the potential consequences of refusing these services;

389.6 (4) the right to be told in advance of any ~~change~~ recommended changes by the
389.7 provider in the service plan ~~of care~~ and to take an active part in any ~~change~~ decisions
389.8 about changes to the service plan;

389.9 (5) the right to refuse services or treatment;

389.10 (6) the right to know, ~~in advance~~ before receiving services or during the initial
389.11 visit, any limits to the services available from a home care provider~~, and the provider's~~
389.12 ~~grounds for a termination of services~~;

389.13 ~~(7) the right to know in advance of receiving care whether the services are covered~~
389.14 ~~by health insurance, medical assistance, or other health programs, the charges for services~~
389.15 ~~that will not be covered by Medicare, and the charges that the individual may have to pay;~~

389.16 ~~(8)~~ (7) the right to ~~know~~ be told before services are initiated what the provider
389.17 charges are for the services, ~~no matter who will be paying the bill~~ and if known to what
389.18 extent payment may be expected from health insurance, public programs or other sources,
389.19 and what charges the client may be responsible for paying;

389.20 ~~(9)~~ (8) the right to know that there may be other services available in the community,
389.21 including other home care services and providers, and to know where to ~~go for~~ find
389.22 information about these services;

389.23 ~~(10)~~ (9) the right to choose freely among available providers and to change providers
389.24 after services have begun, within the limits of health insurance, long-term care insurance,
389.25 medical assistance, or other health programs;

389.26 ~~(11)~~ (10) the right to have personal, financial, and medical information kept private,
389.27 and to be advised of the provider's policies and procedures regarding disclosure of such
389.28 information;

389.29 ~~(12)~~ (11) the right to ~~be allowed~~ access ~~to~~ the client's own records and written
389.30 information from those records in accordance with sections 144.291 to 144.298;

389.31 ~~(13)~~ (12) the right to be served by people who are properly trained and competent
389.32 to perform their duties;

389.33 ~~(14)~~ (13) the right to be treated with courtesy and respect, and to have the ~~patient's~~
389.34 client's property treated with respect;

390.1 (15) (14) the right to be free from physical and verbal abuse, neglect, financial
390.2 exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and
390.3 the Maltreatment of Minors Act;
390.4 (16) (15) the right to reasonable, advance notice of changes in services or charges,
390.5 including;
390.6 (16) the right to know the provider's reason for termination of services;
390.7 (17) the right to at least ten days' advance notice of the termination of a service by a
390.8 provider, except in cases where:
390.9 (i) the recipient of services client engages in conduct that significantly alters the
390.10 conditions of employment as specified in the employment contract between terms of
390.11 the service plan with the home care provider and the individual providing home care
390.12 services, or creates;
390.13 (ii) the client, person who lives with the client, or others create an abusive or unsafe
390.14 work environment for the individual person providing home care services; or
390.15 (ii) (iii) an emergency for the informal caregiver or a significant change in the
390.16 recipient's client's condition has resulted in service needs that exceed the current service
390.17 provider agreement plan and that cannot be safely met by the home care provider;
390.18 (17) (18) the right to a coordinated transfer when there will be a change in the
390.19 provider of services;
390.20 (18) (19) the right to voice grievances regarding treatment or care that is complain
390.21 about services that are provided, or fails to be, furnished, or regarding fail to be provided,
390.22 and the lack of courtesy or respect to the patient client or the patient's client's property;
390.23 (19) (20) the right to know how to contact an individual associated with the home
390.24 care provider who is responsible for handling problems and to have the home care provider
390.25 investigate and attempt to resolve the grievance or complaint;
390.26 (20) (21) the right to know the name and address of the state or county agency to
390.27 contact for additional information or assistance; and
390.28 (21) (22) the right to assert these rights personally, or have them asserted by
390.29 the patient's family or guardian when the patient has been judged incompetent, client's
390.30 representative or by anyone on behalf of the client, without retaliation.
390.31 Subd. 2. **Interpretation and enforcement of rights.** These rights are established
390.32 for the benefit of persons clients who receive home care services. "Home care services"
390.33 means home care services as defined in section 144A.43, subdivision 3, and unlicensed
390.34 personal care assistance services, including services covered by medical assistance under
390.35 section 256B.0625, subdivision 19a. All home care providers, including those exempted
390.36 under section 144A.471, must comply with this section. The commissioner shall enforce

this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a ~~person~~ client to surrender any of these rights as a condition of receiving services. ~~A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights.~~ This statement of rights does not replace or diminish other rights and liberties that may exist relative to ~~persons~~ clients receiving home care services, persons providing home care services, or providers licensed under ~~Laws 1987, chapter 378. A copy of these rights must be provided to an individual at the time home care services, including personal care assistance services, are initiated. The copy shall also contain the address and phone number of the Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of Ombudsman for Long-Term Care shall be included in notices of change in client fees and in notices where home care providers initiate transfer or discontinuation of services~~ sections 144A.43 to 144A.482.

Sec. 7. Minnesota Statutes 2012, section 144A.45, is amended to read:

144A.45 REGULATION OF HOME CARE SERVICES.

Subdivision 1. **~~Rules~~ Regulations.** The commissioner shall ~~adopt rules for the regulation of~~ regulate home care providers pursuant to sections 144A.43 to ~~144A.47~~ 144A.482. The ~~rules~~ regulations shall include the following:

(1) provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services while respecting clients' autonomy and choice;

(2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to ~~144A.47~~ 144A.482;

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

(4) standards for provision of home care services;

~~(4)~~ (5) standards for medication management ~~which may vary according to the nature of the services provided, the setting in which the services are provided, or the status of the consumer. Medication management includes the central storage, handling, distribution, and administration of medications~~;

~~(5)~~ (6) standards for supervision of home care services ~~requiring supervision by a registered nurse or other appropriate health care professional which must occur on site at least every 62 days, or more frequently if indicated by a clinical assessment, and in~~

392.1 ~~accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that a~~
392.2 ~~person performing home care aide tasks for a class B licensee providing paraprofessional~~
392.3 ~~services does not require nursing supervision~~;

392.4 ~~(6)~~ (7) standards for client evaluation or assessment ~~which may vary according to~~
392.5 ~~the nature of the services provided or the status of the consumer~~;

392.6 ~~(7)~~ (8) requirements for the involvement of a ~~consumer's physician~~ client's health
392.7 care provider, the documentation of ~~physicians'~~ health care providers' orders, if required,
392.8 and the ~~consumer's treatment~~ client's service plan~~, and~~;

392.9 (9) the maintenance of accurate, current ~~clinical~~ client records;

392.10 ~~(8)~~ (10) the establishment of ~~different classes~~ basic and comprehensive levels of
392.11 licenses ~~for different types of providers and different standards and requirements for~~
392.12 ~~different kinds of home care~~ based on services provided; and

392.13 ~~(9) operating procedures required to implement~~ (11) provisions to enforce these
392.14 regulations and the home care bill of rights.

392.15 ~~Subd. 1a.~~ **~~Home care aide tasks.~~** ~~Notwithstanding the provisions of Minnesota~~
392.16 ~~Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting~~
392.17 ~~toileting, transfers, and ambulation if the client is ambulatory and if the client has no~~
392.18 ~~serious acute illness or infectious disease.~~

392.19 ~~Subd. 1b.~~ **~~Home health aide qualifications.~~** ~~Notwithstanding the provisions of~~
392.20 ~~Minnesota Rules, part 4668.0100, subpart 5, a person may perform home health aide tasks~~
392.21 ~~if the person maintains current registration as a nursing assistant on the Minnesota nursing~~
392.22 ~~assistant registry. Maintaining current registration on the Minnesota nursing assistant~~
392.23 ~~registry satisfies the documentation requirements of Minnesota Rules, part 4668.0110,~~
392.24 ~~subpart 3.~~

392.25 Subd. 2. **Regulatory functions.** ~~(a)~~ The commissioner shall:

392.26 (1) ~~evaluate, monitor, and~~ license, survey, and monitor without advance notice, home
392.27 care providers in accordance with sections ~~144A.45 to 144A.47~~ 144A.43 to 144A.482;

392.28 ~~(2) inspect the office and records of a provider during regular business hours without~~
392.29 ~~advance notice to the home care provider;~~

392.30 (2) survey every temporary licensee within one year of the temporary license issuance
392.31 date subject to the temporary licensee providing home care services to a client or clients;

392.32 (3) survey all licensed home care providers on an interval that will promote the
392.33 health and safety of clients;

392.34 ~~(3)~~ (4) with the consent of the ~~consumer~~ client, visit the home where services are
392.35 being provided;

393.1 ~~(4)~~ (5) issue correction orders and assess civil penalties in accordance with section
393.2 144.653, subdivisions 5 to 8, for violations of sections 144A.43 to ~~144A.47 or the rules~~
393.3 ~~adopted under those sections~~ 144A.482;
393.4 ~~(5)~~ (6) take action as authorized in section ~~144A.46, subdivision 3~~ 144A.475; and
393.5 ~~(6)~~ (7) take other action reasonably required to accomplish the purposes of sections
393.6 144A.43 to ~~144A.47~~ 144A.482.
393.7 ~~(b) In the exercise of the authority granted in sections 144A.43 to 144A.47, the~~
393.8 ~~commissioner shall comply with the applicable requirements of section 144.122, the~~
393.9 ~~Government Data Practices Act, and the Administrative Procedure Act.~~
393.10 ~~Subd. 4.~~ ~~**Medicaid reimbursement.**~~ ~~Notwithstanding the provisions of section~~
393.11 ~~256B.37 or state plan requirements to the contrary, certification by the federal Medicare~~
393.12 ~~program must not be a requirement of Medicaid payment for services delivered under~~
393.13 ~~section 144A.4605.~~
393.14 ~~Subd. 5.~~ ~~**Home care providers; services for Alzheimer's disease or related**~~
393.15 ~~**disorder.**~~ ~~(a) If a home care provider licensed under section 144A.46 or 144A.4605 markets~~
393.16 ~~or otherwise promotes services for persons with Alzheimer's disease or related disorders,~~
393.17 ~~the facility's direct care staff and their supervisors must be trained in dementia care.~~
393.18 ~~(b) Areas of required training include:~~
393.19 ~~(1) an explanation of Alzheimer's disease and related disorders;~~
393.20 ~~(2) assistance with activities of daily living;~~
393.21 ~~(3) problem solving with challenging behaviors; and~~
393.22 ~~(4) communication skills.~~
393.23 ~~(c) The licensee shall provide to consumers in written or electronic form a~~
393.24 ~~description of the training program, the categories of employees trained, the frequency~~
393.25 ~~of training, and the basic topics covered.~~

393.26 Sec. 8. **[144A.471] HOME CARE PROVIDER AND HOME CARE SERVICES.**
393.27 Subdivision 1. **License required.** A home care provider may not open, operate,
393.28 manage, conduct, maintain, or advertise itself as a home care provider or provide home
393.29 care services in Minnesota without a temporary or current home care provider license
393.30 issued by the commissioner of health.
393.31 Subd. 2. **Determination of direct home care service.** "Direct home care service"
393.32 means a home care service provided to a client by the home care provider or its employees,
393.33 and not by contract. Factors that must be considered in determining whether an individual
393.34 or a business entity provides at least one home care service directly include, but are not
393.35 limited to, whether the individual or business entity:

394.1 (1) has the right to control, and does control, the types of services provided;
394.2 (2) has the right to control, and does control, when and how the services are provided;
394.3 (3) establishes the charges;
394.4 (4) collects fees from the clients or receives payment from third-party payers on
394.5 the clients' behalf;
394.6 (5) pays individuals providing services compensation on an hourly, weekly, or
394.7 similar basis;
394.8 (6) treats the individuals providing services as employees for the purposes of payroll
394.9 taxes and workers' compensation insurance; and
394.10 (7) holds itself out as a provider of home care services or acts in a manner that
394.11 leads clients or potential clients to believe that it is a home care provider providing home
394.12 care services.
394.13 None of the factors listed in this subdivision is solely determinative.
394.14 Subd. 3. **Determination of regularly engaged.** "Regularly engaged" means
394.15 providing, or offering to provide, home care services as a regular part of a business. The
394.16 following factors must be considered by the commissioner in determining whether an
394.17 individual or a business entity is regularly engaged in providing home care services:
394.18 (1) whether the individual or business entity states or otherwise promotes that the
394.19 individual or business entity provides home care services;
394.20 (2) whether persons receiving home care services constitute a substantial part of the
394.21 individual's or the business entity's clientele; and
394.22 (3) whether the home care services provided are other than occasional or incidental
394.23 to the provision of services other than home care services.
394.24 None of the factors listed in this subdivision is solely determinative.
394.25 Subd. 4. **Penalties for operating without license.** A person involved in the
394.26 management, operation, or control of a home care provider that operates without an
394.27 appropriate license is guilty of a misdemeanor. This section does not apply to a person
394.28 who has no legal authority to affect or change decisions related to the management,
394.29 operation, or control of a home care provider.
394.30 Subd. 5. **Basic and comprehensive levels of licensure.** An applicant seeking
394.31 to become a home care provider must apply for either a basic or comprehensive home
394.32 care license.
394.33 Subd. 6. **Basic home care license provider.** Home care services that can be
394.34 provided with a basic home care license are assistive tasks provided by licensed or
394.35 unlicensed personnel that include:

395.1 (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting,
395.2 and bathing;
395.3 (2) providing standby assistance;
395.4 (3) providing verbal or visual reminders to the client to take regularly scheduled
395.5 medication which includes bringing the client previously set-up medication, medication in
395.6 original containers, or liquid or food to accompany the medication;
395.7 (4) providing verbal or visual reminders to the client to perform regularly scheduled
395.8 treatments and exercises;
395.9 (5) preparing modified diets ordered by a licensed health professional; and
395.10 (6) assisting with laundry, housekeeping, meal preparation, shopping, or other
395.11 household chores and services if the provider is also providing at least one of the activities
395.12 in clauses (1) to (5)
395.13 Subd. 7. **Comprehensive home care license provider.** Home care services that
395.14 may be provided with a comprehensive home care license include any of the basic home
395.15 care services listed in subdivision 6, and one or more of the following:
395.16 (1) services of an advanced practice nurse, registered nurse, licensed practical
395.17 nurse, physical therapist, respiratory therapist, occupational therapist, speech-language
395.18 pathologist, dietician or nutritionist, or social worker;
395.19 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a
395.20 licensed health professional within the person's scope of practice;
395.21 (3) medication management services;
395.22 (4) hands-on assistance with transfers and mobility;
395.23 (5) assisting clients with eating when the clients have complicating eating problems
395.24 as identified in the client record or through an assessment such as difficulty swallowing,
395.25 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
395.26 instruments to be fed; or
395.27 (6) providing other complex or specialty health care services.
395.28 Subd. 8. **Exemptions from home care services licensure.** (a) Except as otherwise
395.29 provided in this chapter, home care services that are provided by the state, counties, or
395.30 other units of government must be licensed under this chapter.
395.31 (b) An exemption under this subdivision does not excuse the exempted individual or
395.32 organization from complying with applicable provisions of the home care bill of rights
395.33 in section 144A.44. The following individuals or organizations are exempt from the
395.34 requirement to obtain a home care provider license:

396.1 (1) an individual or organization that offers, provides, or arranges for personal care
396.2 assistance services under the medical assistance program as authorized under sections
396.3 256B.04, subdivision 16; 256B.0625, subdivision 19a; and 256B.0659;
396.4 (2) a provider that is licensed by the commissioner of human services to provide
396.5 semi-independent living services for persons with developmental disabilities under section
396.6 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;
396.7 (3) a provider that is licensed by the commissioner of human services to provide
396.8 home and community-based services for persons with developmental disabilities under
396.9 section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;
396.10 (4) an individual or organization that provides only home management services, if
396.11 the individual or organization is registered under section 144A.482; or
396.12 (5) an individual who is licensed in this state as a nurse, dietitian, social worker,
396.13 occupational therapist, physical therapist, or speech-language pathologist who provides
396.14 health care services in the home independently and not through any contractual or
396.15 employment relationship with a home care provider or other organization.
396.16 Subd. 9. **Exclusions from home care licensure.** The following are excluded from
396.17 home care licensure and are not required to provide the home care bill of rights:
396.18 (1) an individual or business entity providing only coordination of home care that
396.19 includes one or more of the following:
396.20 (i) determination of whether a client needs home care services, or assisting a client
396.21 in determining what services are needed;
396.22 (ii) referral of clients to a home care provider;
396.23 (iii) administration of payments for home care services; or
396.24 (iv) administration of a health care home established under section 256B.0751;
396.25 (2) an individual who is not an employee of a licensed home care provider if the
396.26 individual:
396.27 (i) only provides services as an independent contractor to one or more licensed
396.28 home care providers;
396.29 (ii) provides no services under direct agreements or contracts with clients; and
396.30 (iii) is contractually bound to perform services in compliance with the contracting
396.31 home care provider's policies and service plans;
396.32 (3) a business that provides staff to home care providers, such as a temporary
396.33 employment agency, if the business:
396.34 (i) only provides staff under contract to licensed or exempt providers;
396.35 (ii) provides no services under direct agreements with clients; and

397.1 (iii) is contractually bound to perform services under the contracting home care
397.2 provider's direction and supervision;
397.3 (4) any home care services conducted by and for the adherents of any recognized
397.4 church or religious denomination for its members through spiritual means, or by prayer
397.5 for healing;
397.6 (5) an individual who only provides home care services to a relative;
397.7 (6) an individual not connected with a home care provider that provides assistance
397.8 with basic home care needs if the assistance is provided primarily as a contribution and
397.9 not as a business;
397.10 (7) an individual not connected with a home care provider that shares housing with
397.11 and provides primarily housekeeping or homemaking services to an elderly or disabled
397.12 person in return for free or reduced-cost housing;
397.13 (8) an individual or provider providing home-delivered meal services;
397.14 (9) an individual providing senior companion services and other Older American
397.15 Volunteer Programs (OAVP) established under the Domestic Volunteer Service Act of
397.16 1973, United States Code, title 42, chapter 66;
397.17 (10) an employee of a nursing home licensed under this chapter or an employee of a
397.18 boarding care home licensed under sections 144.50 to 144.56 who responds to occasional
397.19 emergency calls from individuals residing in a residential setting that is attached to or
397.20 located on property contiguous to the nursing home or boarding care home;
397.21 (11) a member of a professional corporation organized under chapter 319B that
397.22 does not regularly offer or provide home care services as defined in section 144A.43,
397.23 subdivision 3;
397.24 (12) the following organizations established to provide medical or surgical services
397.25 that do not regularly offer or provide home care services as defined in section 144A.43,
397.26 subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit
397.27 corporation organized under chapter 317A, a partnership organized under chapter 323, or
397.28 any other entity determined by the commissioner;
397.29 (13) an individual or agency that provides medical supplies or durable medical
397.30 equipment, except when the provision of supplies or equipment is accompanied by a
397.31 home care service;
397.32 (14) a physician licensed under chapter 147;
397.33 (15) an individual who provides home care services to a person with a developmental
397.34 disability who lives in a place of residence with a family, foster family, or primary caregiver;
397.35 (16) a business that only provides services that are primarily instructional and not
397.36 medical services or health-related support services;

398.1 (17) an individual who performs basic home care services for no more than 14 hours
398.2 each calendar week to no more than one client;
398.3 (18) an individual or business licensed as hospice as defined in sections 144A.75 to
398.4 144A.755 who is not providing home care services independent of hospice service;
398.5 (19) activities conducted by the commissioner of health or a board of health as
398.6 defined in section 145A.02, subdivision 2, including communicable disease investigations
398.7 or testing; or
398.8 (20) administering or monitoring a prescribed therapy necessary to control or
398.9 prevent a communicable disease, or the monitoring of an individual's compliance with a
398.10 health directive as defined in section 144.4172, subdivision 6.

398.11 Sec. 9. **[144A.472] HOME CARE PROVIDER LICENSE; APPLICATION AND**
398.12 **RENEWAL.**

398.13 Subdivision 1. **License applications.** Each application for a home care provider
398.14 license must include information sufficient to show that the applicant meets the
398.15 requirements of licensure, including:
398.16 (1) the applicant's name, e-mail address, physical address, and mailing address,
398.17 including the name of the county in which the applicant resides and has a principal
398.18 place of business;
398.19 (2) the initial license fee in the amount specified in subdivision 7;
398.20 (3) e-mail address, physical address, mailing address, and telephone number of the
398.21 principal administrative office;
398.22 (4) e-mail address, physical address, mailing address, and telephone number of
398.23 each branch office, if any;
398.24 (5) names, e-mail and mailing addresses, and telephone numbers of all owners
398.25 and managerial officials;
398.26 (6) documentation of compliance with the background study requirements of section
398.27 144A.476 for all persons involved in the management, operation, or control of the home
398.28 care provider;
398.29 (7) documentation of a background study as required by section 144.057 for any
398.30 individual seeking employment, paid or volunteer, with the home care provider;
398.31 (8) evidence of workers' compensation coverage as required by sections 176.181
398.32 and 176.182;
398.33 (9) documentation of liability coverage, if the provider has it;
398.34 (10) identification of the license level the provider is seeking;

399.1 (11) documentation that identifies the managerial official who is in charge of
399.2 day-to-day operations and attestation that the person has reviewed and understands the
399.3 home care provider regulations;
399.4 (12) documentation that the applicant has designated one or more owners,
399.5 managerial officials, or employees as an agent or agents, which shall not affect the legal
399.6 responsibility of any other owner or managerial official under this chapter;
399.7 (13) the signature of the officer or managing agent on behalf of an entity, corporation,
399.8 association, or unit of government;
399.9 (14) verification that the applicant has the following policies and procedures in place
399.10 so that if a license is issued, the applicant will implement the policies and procedures
399.11 and keep them current:
399.12 (i) requirements in sections 626.556, reporting of maltreatment of minors, and
399.13 626.557, reporting of maltreatment of vulnerable adults;
399.14 (ii) conducting and handling background studies on employees;
399.15 (iii) orientation, training, and competency evaluations of home care staff, and a
399.16 process for evaluating staff performance;
399.17 (iv) handling complaints from clients, family members, or client representatives
399.18 regarding staff or services provided by staff;
399.19 (v) conducting initial evaluation of clients' needs and the providers' ability to provide
399.20 those services;
399.21 (vi) conducting initial and ongoing client evaluations and assessments and how
399.22 changes in a client's condition are identified, managed, and communicated to staff and
399.23 other health care providers as appropriate;
399.24 (vii) orientation to and implementation of the home care client bill of rights;
399.25 (viii) infection control practices;
399.26 (ix) reminders for medications, treatments, or exercises, if provided; and
399.27 (x) conducting appropriate screenings, or documentation of prior screenings, to
399.28 show that staff are free of tuberculosis, consistent with current United States Centers for
399.29 Disease Control standards; and
399.30 (15) other information required by the department.
399.31 Subd. 2. **Comprehensive home care license applications.** In addition to the
399.32 information and fee required in subdivision 1, applicants applying for a comprehensive
399.33 home care license must also provide verification that the applicant has the following
399.34 policies and procedures in place so that if a license is issued, the applicant will implement
399.35 the policies and procedures in this subdivision and keep them current:

400.1 (1) conducting initial and ongoing assessments of the client's needs by a registered
400.2 nurse or appropriate licensed health professional, including how changes in the client's
400.3 conditions are identified, managed, and communicated to staff and other health care
400.4 providers, as appropriate;
400.5 (2) ensuring that nurses and licensed health professionals have current and valid
400.6 licenses to practice;
400.7 (3) medication and treatment management;
400.8 (4) delegation of home care tasks by registered nurses or licensed health professionals;
400.9 (5) supervision of registered nurses and licensed health professionals; and
400.10 (6) supervision of unlicensed personnel performing delegated home care tasks.
400.11 Subd. 3. **License renewal.** (a) Except as provided in section 144A.475, a license
400.12 may be renewed for a period of one year if the licensee satisfies the following:
400.13 (1) submits an application for renewal in the format provided by the commissioner
400.14 at least 30 days before expiration of the license;
400.15 (2) submits the renewal fee in the amount specified in subdivision 7;
400.16 (3) has provided home care services within the past 12 months;
400.17 (4) complies with sections 144A.43 to 144A.4799;
400.18 (5) provides information sufficient to show that the applicant meets the requirements
400.19 of licensure, including items required under subdivision 1;
400.20 (6) provides verification that all policies under subdivision 1, are current; and
400.21 (7) provides any other information deemed necessary by the commissioner.
400.22 (b) A renewal applicant who holds a comprehensive home care license must also
400.23 provide verification that policies listed under subdivision 2 are current.
400.24 Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately
400.25 licensed if the commissioner determines that the units cannot adequately share supervision
400.26 and administration of services from the main office.
400.27 Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license
400.28 issued by the commissioner may not be transferred to another party. Before acquiring
400.29 ownership of a home care provider business, a prospective applicant must apply for a
400.30 new temporary license. A change of ownership is a transfer of operational control to
400.31 a different business entity, and includes:
400.32 (1) transfer of the business to a different or new corporation;
400.33 (2) in the case of a partnership, the dissolution or termination of the partnership under
400.34 chapter 323A, with the business continuing by a successor partnership or other entity;
400.35 (3) relinquishment of control of the provider to another party, including to a contract
400.36 management firm that is not under the control of the owner of the business' assets;

401.1 (4) transfer of the business by a sole proprietor to another party or entity; or
401.2 (5) in the case of a privately held corporation, the change in ownership or control of
401.3 50 percent or more of the outstanding voting stock.
401.4 Subd. 6. **Notification of changes of information.** The temporary licensee or
401.5 licensee shall notify the commissioner in writing within ten working days after any
401.6 change in the information required in subdivision 1, except the information required in
401.7 subdivision 1, clause (5), is required at the time of license renewal.
401.8 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial
401.9 applicant seeking initial temporary home care licensure must submit the following
401.10 application fee to the commissioner along with a completed application:
401.11 (1) basic home care provider, $2,100; or
401.12 (2) comprehensive home care provider, $4,200.
401.13 (b) A home care provider who is filing a change of ownership as required under
401.14 subdivision 5 must submit the following application fee to the commissioner, along with
401.15 the documentation required for the change of ownership:
401.16 (1) basic home care provider, $2,100; or
401.17 (2) comprehensive home care provider, $4,200.
401.18 (c) A home care provider who is seeking to renew the provider's license shall pay a
401.19 fee to the commissioner based on revenues derived from the provision of home care
401.20 services during the calendar year prior to the year in which the application is submitted,
401.21 according to the following schedule:
401.22 **License Renewal Fee**

	Provider Annual Revenue	**Fee**
401.23–401.24	greater than $1,500,000	$6,625
401.25–401.26	greater than $1,275,000 and no more than $1,500,000	$5,797
401.27–401.28	greater than $1,100,000 and no more than $1,275,000	$4,969
401.29–401.30	greater than $950,000 and no more than $1,100,000	$4,141
401.31–401.32	greater than $850,000 and no more than $950,000	$3,727
401.33–401.34	greater than $750,000 and no more than $850,000	$3,313
401.35–401.36	greater than $650,000 and no more than $750,000	$2,898
401.37–401.38	greater than $550,000 and no more than $650,000	$2,485
401.39–401.40	greater than $450,000 and no more than $550,000	$2,070

402.1 greater than $350,000 and no more than 402.2 $450,000	$1,656
402.3 greater than $250,000 and no more than 402.4 $350,000	$1,242
402.5 greater than $100,000 and no more than 402.6 $250,000	$828
402.7 greater than $25,000 and no more than $100,000	$414
402.8 no more than $25,000	$166

402.9 (d) If requested, the home care provider shall provide the commissioner information
402.10 to verify the provider's annual revenues or other information as needed, including copies
402.11 of documents submitted to the Department of Revenue.

402.12 (e) A temporary license or license applicant, or temporary licensee or licensee that
402.13 knowingly provides the commissioner incorrect revenue amounts for the purpose of
402.14 paying a lower license fee, shall be subject to a civil penalty in the amount of double the
402.15 fee the provider should have paid.

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

402.18 Sec. 10. **[144A.473] ISSUANCE OF TEMPORARY LICENSE AND LICENSE**
402.19 **RENEWAL.**

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

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

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

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

402.35 Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner
402.36 shall issue a temporary license for either the basic or comprehensive home care level. A

403.1 temporary license is effective for one year from the date of issuance. Temporary licensees
403.2 must comply with sections 144A.43 to 144A.482.

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

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

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

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

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

403.28 (b) If the temporary licensee whose basic or comprehensive license has been denied
403.29 disagrees with the conclusions of the commissioner, then the licensee may request a
403.30 reconsideration by the commissioner or commissioner's designee. The reconsideration
403.31 request process will be conducted internally by the commissioner or commissioner's
403.32 designee, and chapter 14 does not apply.

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

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

404.3 Sec. 11. **[144A.474] SURVEYS AND INVESTIGATIONS.**

404.4 Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home care
404.5 provider. Survey frequency may be based on the license level, the provider's compliance
404.6 history, number of clients served, or other factors as determined by the department deemed
404.7 necessary to ensure the health, safety, and welfare of clients and compliance with the law.

404.8 Subd. 2. **Scheduling surveys.** Surveys and investigations shall be conducted
404.9 without advance notice to home care providers. Surveyors may contact the home care
404.10 provider on the day of a survey to arrange for someone to be available at the survey site.
404.11 The contact does not constitute advance notice.

404.12 Subd. 3. **Information provided by home care provider.** The home care provider
404.13 shall provide accurate and truthful information to the department during a survey,
404.14 investigation, or other licensing activities.

404.15 Subd. 4. **Providing client records.** Upon request of a surveyor, home care providers
404.16 shall provide a list of current and past clients or client representatives that includes
404.17 addresses and telephone numbers and any other information requested about the services
404.18 to clients within a reasonable period of time.

404.19 Subd. 5. **Contacting and visiting clients.** Surveyors may contact or visit a home
404.20 care provider's clients to gather information without notice to the home care provider.
404.21 Before visiting a client, a surveyor shall obtain the client's or client's representative's
404.22 permission by telephone, mail, or in person. Surveyors shall inform all clients or client's
404.23 representatives of their right to decline permission for a visit.

404.24 Subd. 6. **Complaint investigations.** Upon receiving information alleging that
404.25 a home care provider has violated or is currently violating a requirement of sections
404.26 144A.43 to 144A.482, 626.556, and 626.557, the commissioner shall investigate the
404.27 complaint according to sections 144A.51 to 144A.54.

404.28 Subd. 7. **Correction orders.** (a) A correction order may be issued whenever the
404.29 commissioner finds upon survey or during a complaint investigation that a home care
404.30 provider, a controlling person, or an employee of the provider is not in compliance with
404.31 sections 144A.43 to 144A.482, 626.556, or 626.557. The correction order shall cite the
404.32 specific rule or statute and document areas of noncompliance and the time allowed for
404.33 correction.

404.34 (b) The commissioner shall mail copies of any correction order to the last known
404.35 address of the home care provider. A copy of each correction order and copies of any

405.1 documentation supplied to the commissioner shall be kept on file by the home care
405.2 provider, and public documents shall be made available for viewing by any person upon
405.3 request. Copies may be kept electronically.
405.4 (c) By the correction order date, the home care provider must document in the
405.5 provider's records any action taken to comply with the correction order. The commissioner
405.6 may request a copy of this documentation and the home care provider's action to respond
405.7 to the correction order in future surveys, upon a complaint investigation, and as otherwise
405.8 needed.
405.9 Subd. 8. **Reconsideration of survey findings.** (a) If the applicant or licensee
405.10 believes that the contents of the commissioner's order for correction are in error, the
405.11 applicant or license holder may ask the commissioner to reconsider the parts of the
405.12 correction order that are alleged to be in error. The request for reconsideration must be
405.13 made in writing and must be postmarked and sent to the commissioner within 20 calendar
405.14 days after receipt of the correction order by the applicant or license holder, and:
405.15 (1) specify the parts of the correction order that are alleged to be in error;
405.16 (2) explain why they are in error; and
405.17 (3) include documentation to support the allegation of error.
405.18 (b) A request for reconsideration does not stay any provisions or requirements of the
405.19 correction order. The commissioner's disposition of a request for reconsideration is final
405.20 and not subject to appeal under chapter 14.
405.21 Subd. 9. **Fines.** (a) The commissioner may assess fines according to this subdivision.
405.22 (b) In addition to any enforcement action authorized under this chapter, the
405.23 commissioner may assess a licensed home care provider a fine from $1,000 to $10,000 for
405.24 any of the following violations:
405.25 (1) failure to report maltreatment of a child under section 626.556 or the
405.26 maltreatment of a vulnerable adult under section 626.557;
405.27 (2) failure to establish and implement procedures for reporting suspected
405.28 maltreatment under section 144A.479, subdivision 6, paragraph (a);
405.29 (3) failure to complete and implement an abuse prevention plan under section
405.30 144.479, subdivision 6, paragraph (b);
405.31 (4) an act, omission, or practice that results in a client's illness, injury, or death or
405.32 places the client at imminent risk including physical abuse, sexual abuse, questionable or
405.33 wrongful death, serious unexplained injuries, or serious medical emergency;
405.34 (5) failure to obtain background check clearance or exemption for direct care staff
405.35 prior to provision of services;
405.36 (6) willful violation of state licensing laws and regulations; and

406.1 (7) violation of employee health status guidance relating to control of infectious
406.2 diseases such as tuberculosis.
406.3 (c) If the commissioner finds that the applicant or a home care provider required to
406.4 be licensed under sections 144A.43 to 144A.482 has not corrected violations identified
406.5 in a survey or complaint investigation that were specified in the correction order or
406.6 conditional license, the commissioner may impose a fine. A notice of noncompliance with
406.7 a correction order must be mailed to the applicant's or provider's last known address. The
406.8 noncompliance notice must list the violations not corrected.
406.9 (d) Fines under this subdivision may be assessed according to paragraph (b), or
406.10 the commissioner may assess a fine other than those identified in paragraph (b) from
406.11 $500 to $2,000 per violation when the provider has failed to correct an order relating to
406.12 violation of state licensing laws.
406.13 (e) The license holder must pay the fines assessed on or before the payment date
406.14 specified. If the license holder fails to fully comply with the order, the commissioner may
406.15 issue a second fine or suspend the license until the license holder complies by paying the
406.16 fine. If the license holder receives state funds, the state, county, or municipal agencies or
406.17 departments responsible for administering the funds shall withhold payments and recover
406.18 any payments made while the license is suspended for failure to pay a fine. A timely
406.19 appeal shall stay payment of the fine until the commissioner issues a final order.
406.20 (f) A license holder shall promptly notify the commissioner in writing, including
406.21 by e-mail, when a violation specified in the order to forfeit a fine is corrected. If upon
406.22 reinspection the commissioner determines that a violation has not been corrected as
406.23 indicated by the order to forfeit a fine, the commissioner may issue a second fine. The
406.24 commissioner shall notify the license holder by mail to the last known address in the
406.25 licensing record that a second fine has been assessed. The license holder may appeal the
406.26 second fine as provided under this subdivision.
406.27 (g) A home care provider that has been assessed a fine under this subdivision has a
406.28 right to a hearing under this section and chapter 14.
406.29 (h) When a fine has been assessed, the license holder may not avoid payment by
406.30 closing, selling, or otherwise transferring the licensed program to a third party. In such an
406.31 event, the license holder shall be personally liable for payment of the fine. In the case
406.32 of a corporation, each controlling individual is personally and jointly liable for payment
406.33 of the fine.
406.34 (i) In addition to any fine imposed under this section, the commissioner may assess
406.35 costs related to an investigation that results in a final order assessing a fine or other
406.36 enforcement action authorized by this chapter.

407.1 (j) Fines collected under this subdivision shall be deposited in the state government
407.2 special revenue fund and credited to an account separate from the revenue collected under
407.3 section 144A.472. Subject to an appropriation by the legislature, the revenue from the
407.4 fines collected may be used by the commissioner for special projects to improve home care
407.5 regulations as recommended by the advisory council established in section 144A.4799.

407.6 Sec. 12. **[144A.475] ENFORCEMENT.**

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

407.10 (1) is in violation of, or during the term of the license has violated, any of the
407.11 requirements in sections 144A.471 to 144A.482;

407.12 (2) permits, aids, or abets the commission of any illegal act in the provision of
407.13 home care;

407.14 (3) performs any act detrimental to the health, safety, and welfare of a client;

407.15 (4) obtains the license by fraud or misrepresentation;

407.16 (5) knowingly made or makes a false statement of a material fact in the application
407.17 for a license or in any other record or report required by this chapter;

407.18 (6) denies representatives of the department access to any part of the home care
407.19 provider's books, records, files, or employees;

407.20 (7) interferes with or impedes a representative of the department in contacting the
407.21 home care provider's clients;

407.22 (8) interferes with or impedes a representative of the department in the enforcement
407.23 of this chapter or has failed to fully cooperate with an inspection, survey, or investigation
407.24 by the department;

407.25 (9) destroys or makes unavailable any records or other evidence relating to the home
407.26 care provider's compliance with this chapter;

407.27 (10) refuses to initiate a background study under section 144.057 or 245A.04;

407.28 (11) fails to timely pay any fines assessed by the department;

407.29 (12) violates any local, city, or township ordinance relating to home care services;

407.30 (13) has repeated incidents of personnel performing services beyond their
407.31 competency level; or

407.32 (14) has operated beyond the scope of the home care provider's license level.

407.33 (b) A violation by a contractor providing the home care services of the home care
407.34 provider is a violation by the home care provider.

408.1 Subd. 2. **Terms to suspension or conditional license.** A suspension or conditional
408.2 license designation may include terms that must be completed or met before a suspension
408.3 or conditional license designation is lifted. A conditional license designation may include
408.4 restrictions or conditions that are imposed on the provider. Terms for a suspension or
408.5 conditional license may include one or more of the following and the scope of each will be
408.6 determined by the commissioner:

408.7 (1) requiring a consultant to review, evaluate, and make recommended changes to
408.8 the home care provider's practices and submit reports to the commissioner at the cost of
408.9 the home care provider;

408.10 (2) requiring supervision of the home care provider or staff practices at the cost
408.11 of the home care provider by an unrelated person who has sufficient knowledge and
408.12 qualifications to oversee the practices and who will submit reports to the commissioner;

408.13 (3) requiring the home care provider or employees to obtain training at the cost of
408.14 the home care provider;

408.15 (4) requiring the home care provider to submit reports to the commissioner;

408.16 (5) prohibiting the home care provider from taking any new clients for a period
408.17 of time; or

408.18 (6) any other action reasonably required to accomplish the purpose of this
408.19 subdivision and section 144A.45, subdivision 2.

408.20 Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license,
408.21 the home care provider shall be entitled to notice and a hearing as provided by sections
408.22 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may,
408.23 without a prior contested case hearing, temporarily suspend a license or prohibit delivery
408.24 of services by a provider for not more than 90 days if the commissioner determines that
408.25 the health or safety of a consumer is in imminent danger, provided:

408.26 (1) advance notice is given to the home care provider;

408.27 (2) after notice, the home care provider fails to correct the problem;

408.28 (3) the commissioner has reason to believe that other administrative remedies are not
408.29 likely to be effective; and

408.30 (4) there is an opportunity for a contested case hearing within the 90 days.

408.31 Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties
408.32 under section 144A.45, subdivision 2, clause (5), and an action against a license under
408.33 this section, a provider must request a hearing no later than 15 days after the provider
408.34 receives notice of the action.

408.35 Subd. 5. **Plan required.** (a) The process of suspending or revoking a license
408.36 must include a plan for transferring affected clients to other providers by the home care

409.1 provider, which will be monitored by the commissioner. Within three business days of
409.2 being notified of the final revocation or suspension action, the home care provider shall
409.3 provide the commissioner, the lead agencies as defined in section 256B.0911, and the
409.4 ombudsman for long-term care with the following information:

409.5 (1) a list of all clients, including full names and all contact information on file;

409.6 (2) a list of each client's representative or emergency contact person, including full
409.7 names and all contact information on file;

409.8 (3) the location or current residence of each client;

409.9 (4) the payor sources for each client, including payor source identification numbers;
409.10 and

409.11 (5) for each client, a copy of the client's service plan, and a list of the types of
409.12 services being provided.

409.13 (b) The revocation or suspension notification requirement is satisfied by mailing the
409.14 notice to the address in the license record. The home care provider shall cooperate with
409.15 the commissioner and the lead agencies during the process of transferring care of clients to
409.16 qualified providers. Within three business days of being notified of the final revocation or
409.17 suspension action, the home care provider must notify and disclose to each of the home
409.18 care provider's clients, or the client's representative or emergency contact persons, that
409.19 the commissioner is taking action against the home care provider's license by providing a
409.20 copy of the revocation or suspension notice issued by the commissioner.

409.21 Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The
409.22 owner and managerial officials of a home care provider whose Minnesota license has not
409.23 been renewed or that has been revoked because of noncompliance with applicable laws or
409.24 rules shall not be eligible to apply for nor will be granted a home care license, including
409.25 other licenses under this chapter, or be given status as an enrolled personal care assistance
409.26 provider agency or personal care assistant by the Department of Human Services under
409.27 section 256B.0659 for five years following the effective date of the nonrenewal or
409.28 revocation. If the owner and managerial officials already have enrollment status, their
409.29 enrollment will be terminated by the Department of Human Services.

409.30 (b) The commissioner shall not issue a license to a home care provider for five
409.31 years following the effective date of license nonrenewal or revocation if the owner or
409.32 managerial official, including any individual who was an owner or managerial official
409.33 of another home care provider, had a Minnesota license that was not renewed or was
409.34 revoked as described in paragraph (a).

409.35 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall
409.36 suspend or revoke, the license of any home care provider that includes any individual

410.1 as an owner or managerial official who was an owner or managerial official of a home
410.2 care provider whose Minnesota license was not renewed or was revoked as described in
410.3 paragraph (a) for five years following the effective date of the nonrenewal or revocation.

410.4 (d) The commissioner shall notify the home care provider 30 days in advance of
410.5 the date of nonrenewal, suspension, or revocation of the license. Within ten days after
410.6 the receipt of the notification, the home care provider may request, in writing, that the
410.7 commissioner stay the nonrenewal, revocation, or suspension of the license. The home
410.8 care provider shall specify the reasons for requesting the stay; the steps that will be taken
410.9 to attain or maintain compliance with the licensure laws and regulations; any limits on the
410.10 authority or responsibility of the owners or managerial officials whose actions resulted in
410.11 the notice of nonrenewal, revocation, or suspension; and any other information to establish
410.12 that the continuing affiliation with these individuals will not jeopardize client health, safety,
410.13 or well-being. The commissioner shall determine whether the stay will be granted within
410.14 30 days of receiving the provider's request. The commissioner may propose additional
410.15 restrictions or limitations on the provider's license and require that the granting of the stay
410.16 be contingent upon compliance with those provisions. The commissioner shall take into
410.17 consideration the following factors when determining whether the stay should be granted:

410.18 (1) the threat that continued involvement of the owners and managerial officials with
410.19 the home care provider poses to client health, safety, and well-being;

410.20 (2) the compliance history of the home care provider; and

410.21 (3) the appropriateness of any limits suggested by the home care provider.

410.22 If the commissioner grants the stay, the order shall include any restrictions or
410.23 limitation on the provider's license. The failure of the provider to comply with any
410.24 restrictions or limitations shall result in the immediate removal of the stay and the
410.25 commissioner shall take immediate action to suspend, revoke, or not renew the license.

410.26 Subd. 7. **Request for hearing.** A request for a hearing must be in writing and must:

410.27 (1) be mailed or delivered to the department or the commissioner's designee;

410.28 (2) contain a brief and plain statement describing every matter or issue contested; and

410.29 (3) contain a brief and plain statement of any new matter that the applicant or home
410.30 care provider believes constitutes a defense or mitigating factor.

410.31 Subd. 8. **Informal conference.** At any time, the applicant or home care provider
410.32 and the commissioner may hold an informal conference to exchange information, clarify
410.33 issues, or resolve issues.

410.34 Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the
410.35 commissioner may bring an action in district court to enjoin a person who is involved in
410.36 the management, operation, or control of a home care provider or an employee of the

411.1 home care provider from illegally engaging in activities regulated by sections 144A.43 to
411.2 144A.482. The commissioner may bring an action under this subdivision in the district
411.3 court in Ramsey County or in the district in which a home care provider is providing
411.4 services. The court may grant a temporary restraining order in the proceeding if continued
411.5 activity by the person who is involved in the management, operation, or control of a home
411.6 care provider, or by an employee of the home care provider, would create an imminent
411.7 risk of harm to a recipient of home care services.

411.8 Subd. 10. **Subpoena.** In matters pending before the commissioner under sections
411.9 144A.43 to 144A.482, the commissioner may issue subpoenas and compel the attendance
411.10 of witnesses and the production of all necessary papers, books, records, documents, and
411.11 other evidentiary material. If a person fails or refuses to comply with a subpoena or
411.12 order of the commissioner to appear or testify regarding any matter about which the
411.13 person may be lawfully questioned or to produce any papers, books, records, documents,
411.14 or evidentiary materials in the matter to be heard, the commissioner may apply to the
411.15 district court in any district, and the court shall order the person to comply with the
411.16 commissioner's order or subpoena. The commissioner of health may administer oaths to
411.17 witnesses or take their affirmation. Depositions may be taken in or outside the state in the
411.18 manner provided by law for the taking of depositions in civil actions. A subpoena or other
411.19 process or paper may be served on a named person anywhere in the state by an officer
411.20 authorized to serve subpoenas in civil actions, with the same fees and mileage and in the
411.21 same manner as prescribed by law for a process issued out of a district court. A person
411.22 subpoenaed under this subdivision shall receive the same fees, mileage, and other costs
411.23 that are paid in proceedings in district court.

411.24 Sec. 13. **[144A.476] BACKGROUND STUDIES.**

411.25 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a)
411.26 Before the commissioner issues a temporary license or renews a license, an owner or
411.27 managerial official is required to complete a background study under section 144.057. No
411.28 person may be involved in the management, operation, or control of a home care provider
411.29 if the person has been disqualified under chapter 245C. If an individual is disqualified
411.30 under section 144.056 or chapter 245C, the individual may request reconsideration of
411.31 the disqualification. If the individual requests reconsideration and the commissioner
411.32 sets aside or rescinds the disqualification, the individual is eligible to be involved in the
411.33 management, operation, or control of the provider. If an individual has a disqualification
411.34 under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's

412.1 disqualification is barred from a set aside, and the individual must not be involved in the
412.2 management, operation, or control of the provider.

412.3 (b) For purposes of this section, owners of a home care provider subject to the
412.4 background check requirement are those individuals whose ownership interest provides
412.5 sufficient authority or control to affect or change decisions related to the operation of the
412.6 home care provider. An owner includes a sole proprietor, a general partner, or any other
412.7 individual whose individual ownership interest can affect the management and direction
412.8 of the policies of the home care provider.

412.9 (c) For the purposes of this section, managerial officials subject to the background
412.10 check requirement are individuals who provide direct contact as defined in section 245C.02,
412.11 subdivision 11, or individuals who have the responsibility for the ongoing management or
412.12 direction of the policies, services, or employees of the home care provider. Data collected
412.13 under this subdivision shall be classified as private data under section 13.02, subdivision 12.

412.14 (d) The department shall not issue any license if the applicant or owner or managerial
412.15 official has been unsuccessful in having a background study disqualification set aside
412.16 under section 144.057 and chapter 245C; if the owner or managerial official, as an owner
412.17 or managerial official of another home care provider, was substantially responsible for
412.18 the other home care provider's failure to substantially comply with sections 144A.43 to
412.19 144A.482; or if an owner that has ceased doing business, either individually or as an
412.20 owner of a home care provider, was issued a correction order for failing to assist clients in
412.21 violation of this chapter.

412.22 Subd. 2. **Employees, contractors, and volunteers.** (a) Employees, contractors,
412.23 and volunteers of a home care provider are subject to the background study required by
412.24 section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall
412.25 be construed to prohibit a home care provider from requiring self-disclosure of criminal
412.26 conviction information.

412.27 (b) Termination of an employee in good faith reliance on information or records
412.28 obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not
412.29 subject the home care provider to civil liability or liability for unemployment benefits.

412.30 Sec. 14. **[144A.477] COMPLIANCE.**

412.31 Subdivision 1. **Medicare-certified providers; coordination of surveys.** If feasible,
412.32 the commissioner shall survey licensees to determine compliance with this chapter at the
412.33 same time as surveys for certification for Medicare if Medicare certification is based on
412.34 compliance with the federal conditions of participation and on survey and enforcement

413.1 by the Department of Health as agent for the United States Department of Health and
413.2 Human Services.

413.3 Subd. 2. **Medicare-certified providers; equivalent requirements.** For home care
413.4 providers licensed to provide comprehensive home care services that are also certified for
413.5 participation in Medicare as a home health agency under Code of Federal Regulations,
413.6 title 42, part 484, the following state licensure regulations are considered equivalent to
413.7 the federal requirements:

413.8 (1) quality management, section 144A.479, subdivision 3;

413.9 (2) personnel records, section 144A.479, subdivision 7;

413.10 (3) acceptance of clients, section 144A.4791, subdivision 4;

413.11 (4) referrals, section 144A.4791, subdivision 5;

413.12 (5) client assessment, sections 144A.4791, subdivision 8, and 144A.4792,
413.13 subdivisions 2 and 3;

413.14 (6) individualized monitoring and reassessment, sections 144A.4791, subdivision
413.15 8, and 144A.4792, subdivisions 2 and 3;

413.16 (7) individualized service plan, sections 144A.4791, subdivision 9, 144A.4792,
413.17 subdivision 5, and 144A.4793, subdivision 3;

413.18 (8) client complaint and investigation process, section 144A.4791, subdivision 11;

413.19 (9) prescription orders, section 144A.4792, subdivisions 13 to 16;

413.20 (10) client records, section 144A.4794, subdivisions 1 to 3;

413.21 (11) qualifications for unlicensed personnel performing delegated tasks, section
413.22 144A.4795;

413.23 (12) training and competency staff, section 144A.4795;

413.24 (13) training and competency for unlicensed personnel, section 144A.4795,
413.25 subdivision 7;

413.26 (14) delegation of home care services, section 144A.4795, subdivision 4;

413.27 (15) availability of contact person, section 144A.4797, subdivision 1; and

413.28 (16) supervision of staff, section 144A.4797, subdivisions 2 and 3.

413.29 Violations of requirements in clauses (1) to (16) may lead to enforcement actions
413.30 under section 144A.474.

413.31 Sec. 15. **[144A.478] INNOVATION VARIANCE.**

413.32 Subdivision 1. **Definition.** For purposes of this section, "innovation variance"
413.33 means a specified alternative to a requirement of this chapter. An innovation variance
413.34 may be granted to allow a home care provider to offer home care services of a type or
413.35 in a manner that is innovative, will not impair the services provided, will not adversely

414.1 affect the health, safety, or welfare of the clients, and is likely to improve the services
414.2 provided. The innovative variance cannot change any of the client's rights under section
414.3 144A.44, home care bill of rights.

414.4 Subd. 2. **Conditions.** The commissioner may impose conditions on the granting of
414.5 an innovation variance that the commissioner considers necessary.

414.6 Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any
414.7 innovation variance and may renew a limited innovation variance.

414.8 Subd. 4. **Applications; innovation variance.** An application for innovation
414.9 variance from the requirements of this chapter may be made at any time, must be made in
414.10 writing to the commissioner, and must specify the following:

414.11 (1) the statute or law from which the innovation variance is requested;

414.12 (2) the time period for which the innovation variance is requested;

414.13 (3) the specific alternative action that the licensee proposes;

414.14 (4) the reasons for the request; and

414.15 (5) justification that an innovation variance will not impair the services provided,
414.16 will not adversely affect the health, safety, or welfare of clients, and is likely to improve
414.17 the services provided.

414.18 The commissioner may require additional information from the home care provider before
414.19 acting on the request.

414.20 Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request
414.21 for an innovation variance in writing within 45 days of receipt of a complete request.
414.22 Notice of a denial shall contain the reasons for the denial. The terms of a requested
414.23 innovation variance may be modified upon agreement between the commissioner and
414.24 the home care provider.

414.25 Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of
414.26 an innovation variance shall be deemed to be a violation of this chapter.

414.27 Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or
414.28 deny renewal of an innovation variance if:

414.29 (1) it is determined that the innovation variance is adversely affecting the health,
414.30 safety, or welfare of the licensee's clients;

414.31 (2) the home care provider has failed to comply with the terms of the innovation
414.32 variance;

414.33 (3) the home care provider notifies the commissioner in writing that it wishes to
414.34 relinquish the innovation variance and be subject to the statute previously varied; or

414.35 (4) the revocation or denial is required by a change in law.

415.1 Sec. 16. **[144A.479] HOME CARE PROVIDER RESPONSIBILITIES;**
415.2 **BUSINESS OPERATION.**

415.3 Subdivision 1. **Display of license.** The original current license must be displayed
415.4 in the home care providers' principal business office and copies must be displayed in
415.5 any branch office. The home care provider must provide a copy of the license to any
415.6 person who requests it.

415.7 Subd. 2. **Advertising.** Home care providers shall not use false, fraudulent,
415.8 or misleading advertising in the marketing of services. For purposes of this section,
415.9 advertising includes any verbal, written, or electronic means of communicating to
415.10 potential clients about the availability, nature, or terms of home care services.

415.11 Subd. 3. **Quality management.** The home care provider shall engage in quality
415.12 management appropriate to the size of the home care provider and relevant to the type
415.13 of services the home care provider provides. The quality management activity means
415.14 evaluating the quality of care by periodically reviewing client services, complaints made,
415.15 and other issues that have occurred and determining whether changes in services, staffing,
415.16 or other procedures need to be made in order to ensure safe and competent services to
415.17 clients. Documentation about quality management activity must be available for two
415.18 years. Information about quality management must be available to the commissioner at
415.19 the time of the survey, investigation, or renewal.

415.20 Subd. 4. **Provider restrictions.** (a) This subdivision does not apply to licensees
415.21 that are Minnesota counties or other units of government.

415.22 (b) A home care provider or staff cannot accept powers-of-attorney from clients for
415.23 any purpose, and may not accept appointments as guardians or conservators of clients.

415.24 (c) A home care provider cannot serve as a client's representative.

415.25 Subd. 5. **Handling of client's finances and property.** (a) A home care provider
415.26 may assist clients with household budgeting, including paying bills and purchasing
415.27 household goods, but may not otherwise manage a client's property. A home care provider
415.28 must provide a client with receipts for all transactions and purchases paid with the clients'
415.29 funds. When receipts are not available, the transaction or purchase must be documented.
415.30 A home care provider must maintain records of all such transactions.

415.31 (b) A home care provider or staff may not borrow a client's funds or personal or
415.32 real property, nor in any way convert a client's property to the home care provider's or
415.33 staff's possession.

415.34 (c) Nothing in this section precludes a home care provider or staff from accepting
415.35 gifts of minimal value, or precludes the acceptance of donations or bequests made to a

416.1 home care provider that are exempt from income tax under section 501(c) of the Internal
416.2 Revenue Code of 1986.
416.3 Subd. 6. **Reporting maltreatment of vulnerable adults and minors.** (a) All
416.4 home care providers must comply with requirements for the reporting of maltreatment
416.5 of minors in section 626.556 and the requirements for the reporting of maltreatment
416.6 of vulnerable adults in section 626.557. Home care providers must report suspected
416.7 maltreatment of minors and vulnerable adults to the common entry point. Each home
416.8 care provider must establish and implement a written procedure to ensure that all cases
416.9 of suspected maltreatment are reported.
416.10 (b) Each home care provider must develop and implement an individual abuse
416.11 prevention plan for each vulnerable minor or adult for whom home care services are
416.12 provided by a home care provider. The plan shall contain an individualized review or
416.13 assessment of the person's susceptibility to abuse by another individual, including other
416.14 vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors;
416.15 and statements of the specific measures to be taken to minimize the risk of abuse to that
416.16 person and other vulnerable adults or minors. For purposes of the abuse prevention plan,
416.17 the term abuse includes self-abuse.
416.18 Subd. 7. **Employee records.** The home care provider must maintain current records
416.19 of each paid employee, regularly scheduled volunteers providing home care services, and
416.20 of each individual contractor providing home care services. The records must include
416.21 the following information:
416.22 (1) evidence of current professional licensure, registration, or certification, if
416.23 licensure, registration, or certification is required by this statute, or other rules;
416.24 (2) records of orientation, required annual training and infection control training,
416.25 and competency evaluations;
416.26 (3) current job description, including qualifications, responsibilities, and
416.27 identification of staff providing supervision;
416.28 (4) documentation of annual performance reviews which identify areas of
416.29 improvement needed and training needs;
416.30 (5) for individuals providing home care services, verification that required health
416.31 screenings under section 144A.4798 have taken place and the dates of those screenings; and
416.32 (6) documentation of the background study as required under section 144.057.
416.33 Each employee record must be retained for at least three years after a paid employee,
416.34 home care volunteer, or contractor ceases to be employed by or under contract with the
416.35 home care provider. If a home care provider ceases operation, employee records must be
416.36 maintained for three years.

417.1 Sec. 17. **[144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH**
417.2 **RESPECT TO CLIENTS.**

417.3 Subdivision 1. **Home care bill of rights; notification to client.** (a) The home
417.4 care provider shall provide the client or the client's representative a written notice of the
417.5 rights under section 144A.44 in a language that the client or the client's representative
417.6 can understand before the initiation of services to that client. If a written version is not
417.7 available, the home care bill of rights must be communicated to the client or client's
417.8 representative in a language they can understand.

417.9 (b) In addition to the text of the home care bill of rights in section 144A.44,
417.10 subdivision 1, the notice shall also contain the following statement describing how to file
417.11 a complaint with these offices.

417.12 "If you have a complaint about the provider or the person providing your
417.13 home care services, you may call, write, or visit the Office of Health Facility
417.14 Complaints, Minnesota Department of Health. You may also contact the Office of
417.15 Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health
417.16 and Developmental Disabilities."

417.17 The statement should include the telephone number, Web site address, e-mail
417.18 address, mailing address, and street address of the Office of Health Facility Complaints at
417.19 the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care,
417.20 and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The
417.21 statement should also include the home care provider's name, address, e-mail, telephone
417.22 number, and name or title of the person at the provider to whom problems or complaints
417.23 may be directed. It must also include a statement that the home care provider will not
417.24 retaliate because of a complaint.

417.25 (c) The home care provider shall obtain written acknowledgment of the client's
417.26 receipt of the home care bill of rights or shall document why an acknowledgment cannot
417.27 be obtained. The acknowledgment may be obtained from the client or the client's
417.28 representative. Acknowledgment of receipt shall be retained in the client's record.

417.29 Subd. 2. **Notice of services for dementia, Alzheimer's disease, or related**
417.30 **disorders.** The home care provider that provides services to clients with dementia shall
417.31 provide in written or electronic form, to clients and families or other persons who request
417.32 it, a description of the training program and related training it provides, including the
417.33 categories of employees trained, the frequency of training, and the basic topics covered.
417.34 This information satisfies the disclosure requirements in section 325F.72, subdivision
417.35 2, clause (4).

418.1 Subd. 3. **Statement of home care services.** Prior to the initiation of services,
418.2 a home care provider must provide to the client or the client's representative a written
418.3 statement which identifies if they have a basic or comprehensive home care license, the
418.4 services they are authorized to provide, and which services they cannot provide under the
418.5 scope of their license. The home care provider shall obtain written acknowledgment
418.6 from the clients that they have provided the statement or must document why they could
418.7 not obtain the acknowledgment.
418.8 Subd. 4. **Acceptance of clients.** No home care provider may accept a person as a
418.9 client unless the home care provider has staff, sufficient in qualifications, competency,
418.10 and numbers, to adequately provide the services agreed to in the service plan and that
418.11 are within the provider's scope of practice.
418.12 Subd. 5. **Referrals.** If a home care provider reasonably believes that a client is in
418.13 need of another medical or health service, including a licensed health professional, or
418.14 social service provider, the home care provider shall:
418.15 (1) determine the client's preferences with respect to obtaining the service; and
418.16 (2) inform the client of resources available, if known, to assist the client in obtaining
418.17 services.
418.18 Subd. 6. **Initiation of services.** When a provider initiates services and the
418.19 individualized review or assessment required in subdivisions 7 and 8 has not been
418.20 completed, the provider must complete a temporary plan and agreement with the client for
418.21 services.
418.22 Subd. 7. **Basic individualized client review and monitoring.** (a) When services
418.23 being provided are basic home care services, an individualized initial review of the client's
418.24 needs and preferences must be conducted at the client's residence with the client or client's
418.25 representative. This initial review must be completed within 30 days after the initiation of
418.26 the home care services.
418.27 (b) Client monitoring and review must be conducted as needed based on changes
418.28 in the needs of the client and cannot exceed 90 days from the date of the last review.
418.29 The monitoring and review may be conducted at the client's residence or through the
418.30 utilization of telecommunication methods based on practice standards that meet the
418.31 individual client's needs.
418.32 Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When
418.33 the services being provided are comprehensive home care services, an individualized
418.34 initial assessment must be conducted in-person by a registered nurse. When the services
418.35 are provided by other licensed health professionals, the assessment must be conducted by

419.1 the appropriate health professional. This initial assessment must be completed within five
419.2 days after initiation of home care services.
419.3 (b) Client monitoring and reassessment must be conducted in the client's home no
419.4 more than 14 days after initiation of services.
419.5 (c) Ongoing client monitoring and reassessment must be conducted as needed based
419.6 on changes in the needs of the client and cannot exceed 90 days from the last date of the
419.7 assessment. The monitoring and reassessment may be conducted at the client's residence
419.8 or through the utilization of telecommunication methods based on practice standards that
419.9 meet the individual client's needs.
419.10 Subd. 9. **Service plan, implementation, and revisions to service plan.** (a) No later
419.11 than 14 days after the initiation of services, a home care provider shall finalize a current
419.12 written service plan.
419.13 (b) The service plan and any revisions must include a signature or other
419.14 authentication by the home care provider and by the client or the client's representative
419.15 documenting agreement on the services to be provided. The service plan must be revised,
419.16 if needed, based on client review or reassessment under subdivisions 7 and 8. The provider
419.17 must provide information to the client about changes to the provider's fee for services and
419.18 how to contact the Office of the Ombudsman for Long-Term Care.
419.19 (c) The home care provider must implement and provide all services required by
419.20 the current service plan.
419.21 (d) The service plan and revised service plan must be entered into the client's record,
419.22 including notice of a change in a client's fees when applicable.
419.23 (e) Staff providing home care services must be informed of the current written
419.24 service plan.
419.25 (f) The service plan must include:
419.26 (1) a description of the home care services to be provided, the fees for services, and
419.27 the frequency of each service, according to the client's current review or assessment and
419.28 client preferences;
419.29 (2) the identification of the staff or categories of staff who will provide the services;
419.30 (3) the schedule and methods of monitoring reviews or assessments of the client;
419.31 (4) the frequency of sessions of supervision of staff and type of personnel who
419.32 will supervise staff; and
419.33 (5) a contingency plan that includes:
419.34 (i) the action to be taken by the home care provider and by the client or client's
419.35 representative if the scheduled service cannot be provided;

420.1 (ii) information and method for a client or client's representative to contact the
420.2 home care provider;
420.3 (iii) names and contact information of persons the client wishes to have notified
420.4 in an emergency or if there is a significant adverse change in the client's condition,
420.5 including identification of and information as to who has authority to sign for the client in
420.6 an emergency; and
420.7 (iv) the circumstances in which emergency medical services are not to be summoned
420.8 consistent with chapters 145B and 145C, and declarations made by the client under those
420.9 chapters.
420.10 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a
420.11 service plan with a client, and the client continues to need home care services, the home
420.12 care provider shall provide the client and the client's representative, if any, with a written
420.13 notice of termination which includes the following information:
420.14 (1) the effective date of termination;
420.15 (2) the reason for termination;
420.16 (3) a list of known licensed home care providers in the client's immediate geographic
420.17 area;
420.18 (4) a statement that the home care provider will participate in a coordinated transfer
420.19 of care of the client to another home care provider, health care provider, or caregiver, as
420.20 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);
420.21 (5) the name and contact information of a person employed by the home care
420.22 provider with whom the client may discuss the notice of termination; and
420.23 (6) if applicable, a statement that the notice of termination of home care services
420.24 does not constitute notice of termination of the housing with services contract with a
420.25 housing with services establishment.
420.26 (b) When the home care provider voluntarily discontinues services to all clients, the
420.27 home care provider must notify the commissioner, lead agencies, and the ombudsman for
420.28 long-term care about its clients and comply with the requirements in this subdivision.
420.29 Subd. 11. **Client complaint and investigative process.** (a) The home care
420.30 provider must have a written policy and system for receiving, investigating, reporting,
420.31 and attempting to resolve complaints from its clients or clients' representatives. The
420.32 policy should clearly identify the process by which clients may file a complaint or concern
420.33 about home care services and an explicit statement that the home care provider will not
420.34 discriminate or retaliate against a client for expressing concerns or complaints. A home
420.35 care provider must have a process in place to conduct investigations of complaints made
420.36 by the client or the client's representative about the services in the client's plan that are or

421.1 are not being provided or other items covered in the client's home care bill of rights. This
421.2 complaint system must provide reasonable accommodations for any special needs of the
421.3 client or client's representative if requested.

421.4 (b) The home care provider must document the complaint, name of the client,
421.5 investigation, and resolution of each complaint filed. The home care provider must
421.6 maintain a record of all activities regarding complaints received, including the date the
421.7 complaint was received, and the home care provider's investigation and resolution of the
421.8 complaint. This complaint record must be kept for each event for at least two years after
421.9 the date of entry and must be available to the commissioner for review.

421.10 (c) The required complaint system must provide for written notice to each client or
421.11 client's representative that includes:

421.12 (1) the client's right to complain to the home care provider about the services received;

421.13 (2) the name or title of the person or persons with the home care provider to contact
421.14 with complaints;

421.15 (3) the method of submitting a complaint to the home care provider; and

421.16 (4) a statement that the provider is prohibited against retaliation according to
421.17 paragraph (d).

421.18 (d) A home care provider must not take any action that negatively affects a client
421.19 in retaliation for a complaint made or a concern expressed by the client or the client's
421.20 representative.

421.21 Subd. 12. **Disaster planning and emergency preparedness plan.** The home care
421.22 provider must have a written plan of action to facilitate the management of the client's care
421.23 and services in response to a natural disaster, such as flood and storms, or other emergencies
421.24 that may disrupt the home care provider's ability to provide care or services. The licensee
421.25 must provide adequate orientation and training of staff on emergency preparedness.

421.26 Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a
421.27 client, family member, or other caregiver of the client requests that an employee or other
421.28 agent of the home care provider discontinue a life-sustaining treatment, the employee or
421.29 agent receiving the request:

421.30 (1) shall take no action to discontinue the treatment; and

421.31 (2) shall promptly inform their supervisor or other agent of the home care provider
421.32 of the client's request.

421.33 (b) Upon being informed of a request for termination of treatment, the home care
421.34 provider shall promptly:

421.35 (1) inform the client that the request will be made known to the physician who
421.36 ordered the client's treatment;

422.1 (2) inform the physician of the client's request; and
422.2 (3) work with the client and the client's physician to comply with the provisions of
422.3 the Health Care Directive Act in chapter 145C.
422.4 (c) This section does not require the home care provider to discontinue treatment,
422.5 except as may be required by law or court order.
422.6 (d) This section does not diminish the rights of clients to control their treatments,
422.7 refuse services, or terminate their relationships with the home care provider.
422.8 (e) This section shall be construed in a manner consistent with chapter 145B or
422.9 145C, whichever applies, and declarations made by clients under those chapters.

422.10 Sec. 18. **[144A.4792] MEDICATION MANAGEMENT.**
422.11 Subdivision 1. **Medication management services; comprehensive home care**
422.12 **license.** (a) This subdivision applies only to home care providers with a comprehensive
422.13 home care license that provides medication management services to clients. Medication
422.14 management services may not be provided by a home care provider that has a basic
422.15 home care license.
422.16 (b) A comprehensive home care provider who provides medication management
422.17 services must develop, implement, and maintain current written medication management
422.18 policies and procedures. The policies and procedures must be developed under the
422.19 supervision and direction of a registered nurse, licensed health professional, or pharmacist
422.20 consistent with current practice standards and guidelines.
422.21 (c) The written policies and procedures must address requesting and receiving
422.22 prescriptions for medications; preparing and giving medications; verifying that
422.23 prescription drugs are administered as prescribed; documenting medication management
422.24 activities; controlling and storing medications; monitoring and evaluating medication use;
422.25 resolving medication errors; communicating with the prescriber, pharmacist, and client
422.26 and client representative, if any; disposing of unused medications; and educating clients
422.27 and client representatives about medications. When controlled substances are being
422.28 managed, the policies and procedures must also identify how the provider will ensure
422.29 security and accountability for the overall management, control, and disposition of those
422.30 substances in compliance with state and federal regulations and with subdivision 22.
422.31 Subd. 2. **Provision of medication management services.** (a) For each client who
422.32 requests medication management services, the comprehensive home care provider shall,
422.33 prior to providing medication management services, have a registered nurse, licensed
422.34 health professional, or authorized prescriber under section 151.37 conduct an assessment
422.35 to determine what mediation management services will be provided and how the services

423.1 will be provided. This assessment must be conducted face-to-face with the client. The
423.2 assessment must include an identification and review of all medications the client is known
423.3 to be taking. The review and identification must include indications for medications, side
423.4 effects, contraindications, allergic or adverse reactions, and actions to address these issues.

423.5 (b) The assessment must identify interventions needed in management of
423.6 medications to prevent diversion of medication by the client or others who may have
423.7 access to the medications. Diversion of medications means the misuse, theft, or illegal
423.8 or improper disposition of medications.

423.9 Subd. 3. **Individualized medication monitoring and reassessment.** The
423.10 comprehensive home care provider must monitor and reassess the client's medication
423.11 management services as needed under subdivision 14 when the client presents with
423.12 symptoms or other issues that may be medication-related and, at a minimum, annually.

423.13 Subd. 4. **Client refusal.** The home care provider must document in the client's
423.14 record any refusal for an assessment for medication management by the client. The
423.15 provider must discuss with the client the possible consequences of the client's refusal and
423.16 document the discussion in the client's record.

423.17 Subd. 5. **Individualized medication management plan.** For each client receiving
423.18 medication management services, the comprehensive home care provider must prepare
423.19 and include in the service plan a written medication management plan. The written plan
423.20 must be updated when changes are made to the plan. The plan must contain at least the
423.21 following provisions:

423.22 (1) a statement describing the medication management services that will be provided;

423.23 (2) a description of storage of medications based on the client's needs and
423.24 preferences, risk of diversion, and consistent with the manufacturer's directions;

423.25 (3) procedures for documenting medications that clients are taking;

423.26 (4) procedures for verifying all prescription drugs are administered as prescribed;

423.27 (5) procedures for monitoring medication use to prevent possible complications or
423.28 adverse reactions;

423.29 (6) identification of persons responsible for monitoring medication supplies and
423.30 ensuring that medication refills are ordered on a timely basis;

423.31 (7) identification of medication management tasks that may be delegated to
423.32 unlicensed personnel; and

423.33 (8) procedures for staff notifying a registered nurse or appropriate licensed health
423.34 professional when a problem arises with medication management services.

423.35 Subd. 6. **Administration of medication.** Medications may be administered by a
423.36 nurse, physician, or other licensed health practitioner authorized to administer medications

424.1 or by unlicensed personnel who have been delegated medication administration tasks by
424.2 a registered nurse.

424.3 Subd. 7. **Delegation of medication administration.** When administration of
424.4 medications is delegated to unlicensed personnel, the comprehensive home care provider
424.5 must ensure that the registered nurse has:

424.6 (1) instructed the unlicensed personnel in the proper methods to administer the
424.7 medications with respect to each client, and the unlicensed personnel has demonstrated
424.8 ability to competently follow the procedures;

424.9 (2) specified, in writing, specific instructions for each client and documented those
424.10 instructions in the client's records; and

424.11 (3) communicated with the unlicensed personnel about the individual needs of
424.12 the client.

424.13 Subd. 8. **Documentation of administration of medications.** Each medication
424.14 administered by comprehensive home care provider staff must be documented in the
424.15 client's record. The documentation must include the signature and title of the person
424.16 who administered the medication. The documentation must include the medication
424.17 name, dosage, date and time administered, and method and route of administration. The
424.18 staff must document the reason why medication administration was not completed as
424.19 prescribed and document any follow-up procedures that were provided to meet the client's
424.20 needs when medication was not administered as prescribed and in compliance with the
424.21 client's medication management plan.

424.22 Subd. 9. **Documentation of medication set up.** Documentation of dates of
424.23 medication set up, name of medication, quantity of dose, times to be administered, route
424.24 of administration, and name of person completing medication set up must be done at
424.25 time of set up.

424.26 Subd. 10. **Medications when client is away from home.** (a) A home care provider
424.27 providing medication management services must develop a policy and procedures for the
424.28 issuance of medications to clients for planned and unplanned times the client will be
424.29 away from home and need to have their medications with them which complies with
424.30 the following:

424.31 (1) for planned time away, the medications must be obtained from the pharmacy or
424.32 set up by the registered nurse according to appropriate state and federal laws and nurse
424.33 standards of practice; and

424.34 (2) for unplanned times away from home for temporary periods when an adequate
424.35 medication supply cannot be obtained from the pharmacy or set up by the registered nurse in
424.36 a timely manner, the provider may allow an unlicensed personnel to set up the medications.

425.1 (b) The task of medication set up may be done by an unlicensed personnel who is
425.2 trained and has been determined competent according to subdivisions 6 and 7. Prior
425.3 to providing the medications to the client, the unlicensed personnel must speak with
425.4 the registered nurse to ensure that all appropriate precautions are taken. The unlicensed
425.5 personnel may provide the client or the client's representative up to a 72-hour supply of
425.6 the client's medications.

425.7 (c) When preparing the medications, the medications must be taken from the
425.8 original containers prepared by the pharmacist and then placed in a suitable container. The
425.9 container must be labeled with the client's name; the medication name, strength, dose, and
425.10 route of administration; and the dates and times the medications are to be taken by the
425.11 client and any other information that the client should know regarding the medications.
425.12 For those medications which cannot be prepared in advance, the client must be given
425.13 the original container and complete directions and information for the administration
425.14 of that medication.

425.15 (d) The client or client's representative must also be provided in writing with the home
425.16 care provider's name and contact information for the home care provider's registered nurse.
425.17 The unlicensed personnel must document in the client's record the date the medications
425.18 were provided to the client; the name of medication; the medication's strength, dose, and
425.19 routes and administration times; the amounts of medications that were provided to the
425.20 client and to whom the medications were given. The registered nurse must review the
425.21 set up of medication and documentation to ensure that the issuance of medications by the
425.22 unlicensed personnel was handled appropriately.

425.23 Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home
425.24 care provider must determine whether it will require a prescription for all medications it
425.25 manages. The comprehensive home care provider must inform the client or the client's
425.26 representative whether the comprehensive home care provider requires a prescription
425.27 for all over-the-counter and dietary supplements before the comprehensive home care
425.28 provider will agree to manage those medications.

425.29 Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.**
425.30 A comprehensive home care provider providing medication management services for
425.31 over-the-counter drugs or dietary supplements must retain those items in the original labeled
425.32 container with directions for use prior to setting up for immediate or later administration.
425.33 The provider must verify that the medications are up-to-date and stored as appropriate.

425.34 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
425.35 prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed
425.36 medications that the comprehensive home care provider is managing for the client.

426.1 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least
426.2 every 12 months or more frequently as indicated by the assessment in subdivision 2.
426.3 Prescriptions for controlled substances must comply with chapter 152.

426.4 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an
426.5 authorized prescriber must be received by a nurse or pharmacist. The order must be
426.6 handled according to Minnesota Rules, part 6800.6200.

426.7 Subd. 16. **Written or electronic prescription.** When a written or electronic
426.8 prescription is received, it must be communicated to the registered nurse in charge and
426.9 recorded or placed in the client's record.

426.10 Subd. 17. **Records confidential.** A prescription or order received verbally, in
426.11 writing, or electronically must be kept confidential according to sections 144.291 to
426.12 144.298 and 144A.44.

426.13 Subd. 18. **Medications provided by client or family members.** When the
426.14 comprehensive home care provider is aware of any medications or dietary supplements
426.15 that are being used by the client and are not included in the assessment for medication
426.16 management services, the staff must advise the registered nurse and document that in
426.17 the client's record.

426.18 Subd. 19. **Storage of drugs.** A comprehensive home care provider providing
426.19 storage of medications outside of the client's private living space must store all prescription
426.20 drugs in securely locked and substantially constructed compartments according to the
426.21 manufacturer's directions and permit only authorized personnel to have access.

426.22 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for
426.23 immediate or later administration, must be kept in the original container in which it was
426.24 dispensed by the pharmacy bearing the original prescription label with legible information
426.25 including the expiration or beyond-use date of a time-dated drug.

426.26 Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or
426.27 saved for use by anyone other than the client.

426.28 Subd. 22. **Disposition of drugs.** (a) Any current medications being managed by the
426.29 comprehensive home care provider must be given to the client or the client's representative
426.30 when the client's service plan ends or medication management services are no longer part
426.31 of the service plan. Medications that have been stored in the client's private living space
426.32 for a client that is deceased or that have been discontinued or that have expired may be
426.33 given to the client or the client's representative for disposal.

426.34 (b) The comprehensive home care provider will dispose of any medications
426.35 remaining with the comprehensive home care provider that are discontinued or expired or

427.1 upon the termination of the service contract or the client's death according to state and
427.2 federal regulations for disposition of drugs and controlled substances.

427.3 (c) Upon disposition, the comprehensive home care provider must document in the
427.4 client's record the disposition of the medications including the medication's name, strength,
427.5 prescription number as applicable, quantity, to whom the medications were given, date of
427.6 disposition, and names of staff and other individuals involved in the disposition.

427.7 Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing
427.8 medication management must develop and implement procedures for loss or spillage of all
427.9 controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must
427.10 require that when a spillage of a controlled substance occurs, a notation must be made
427.11 in the client's record explaining the spillage and the actions taken. The notation must
427.12 be signed by the person responsible for the spillage and include verification that any
427.13 contaminated substance was disposed of according to state or federal regulations.

427.14 (b) The procedures must require the comprehensive home care provider of
427.15 medication management to investigate any known loss or unaccounted for prescription
427.16 drugs and take appropriate action required under state or federal regulations and document
427.17 the investigation in required records.

427.18 Sec. 19. **[144A.4793] TREATMENT AND THERAPY MANAGEMENT**
427.19 **SERVICES.**

427.20 Subdivision 1. **Providers with a comprehensive home care license.** This section
427.21 applies only to home care providers with a comprehensive home care license that provide
427.22 treatment or therapy management services to clients. Treatment or therapy management
427.23 services cannot be provided by a home care provider that has a basic home care license.

427.24 Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who
427.25 provides treatment and therapy management services must develop, implement, and
427.26 maintain up-to-date written treatment or therapy management policies and procedures.
427.27 The policies and procedures must be developed under the supervision and direction of
427.28 a registered nurse or appropriate licensed health professional consistent with current
427.29 practice standards and guidelines.

427.30 (b) The written policies and procedures must address requesting and receiving
427.31 orders or prescriptions for treatments or therapies, providing the treatment or therapy,
427.32 documenting of treatment or therapy activities, educating and communicating with clients
427.33 about treatments or therapy they are receiving, monitoring and evaluating the treatment
427.34 and therapy, and communicating with the prescriber.

428.1 Subd. 3. **Individualized treatment or therapy management plan.** For each
428.2 client receiving management of ordered or prescribed treatments or therapy services, the
428.3 comprehensive home care provider must include in the service plan a written management
428.4 plan which contains at least the following provisions:

428.5 (1) a statement of the type of services that will be provided;

428.6 (2) procedures for documenting treatments or therapies the client is receiving;

428.7 (3) procedures for monitoring treatments or therapy to prevent possible
428.8 complications or adverse reactions;

428.9 (4) identification of treatment or therapy tasks that will be delegated to unlicensed
428.10 personnel; and

428.11 (5) procedures for notifying a registered nurse or appropriate licensed health
428.12 professional when a problem arises with treatments or therapy services.

428.13 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed
428.14 treatments or therapies must be administered by a nurse, physician, or other licensed health
428.15 professional authorized to perform the treatment or therapy, or may be delegated or assigned
428.16 to unlicensed personnel by the licensed health professional according to the appropriate
428.17 practice standards for delegation or assignment. When administration of a treatment or
428.18 therapy is delegated or assigned to unlicensed personnel, the home care provider must
428.19 ensure that the registered nurse or authorized licensed health professional has:

428.20 (1) instructed the unlicensed personnel in the proper methods with respect to each
428.21 client and has demonstrated their ability to competently follow the procedures;

428.22 (2) specified, in writing, specific instructions for each client and documented those
428.23 instructions in the client's record; and

428.24 (3) communicated with the unlicensed personnel about the individual needs of
428.25 the client.

428.26 Subd. 5. **Documentation of administration of treatments and therapies.** Each
428.27 treatment or therapy administered by a comprehensive home care provider must be
428.28 documented in the client's record. The documentation must include the signature and title
428.29 of the person who administered the treatment or therapy and must include the date and
428.30 time of administration. When treatment or therapies are not administered as ordered or
428.31 prescribed, the provider must document the reason why it was not administered and any
428.32 follow-up procedures that were provided to meet the client's needs.

428.33 Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or
428.34 electronically recorded order or prescription for all treatments and therapies. The order
428.35 must contain the name of the client, description of the treatment or therapy to be provided,
428.36 and the frequency and other information needed to administer the treatment or therapy.

429.1 Sec. 20. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

429.2 Subdivision 1. **Client record.** (a) The home care provider must maintain records
429.3 for each client for whom it is providing services. Entries in the client records must be
429.4 current, legible, permanently recorded, dated, and authenticated with the name and title
429.5 of the person making the entry.

429.6 (b) Client records, whether written or electronic, must be protected against loss,
429.7 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable
429.8 relevant federal and state laws. The home care provider shall establish and implement
429.9 written procedures to control use, storage, and security of client's records and establish
429.10 criteria for release of client information.

429.11 (c) The home care provider may not disclose to any other person any personal,
429.12 financial, medical, or other information about the client, except:

429.13 (1) as may be required by law;

429.14 (2) to employees or contractors of the home care provider, another home care
429.15 provider, other health care practitioner or provider, or inpatient facility needing
429.16 information in order to provide services to the client, but only such information that
429.17 is necessary for the provision of services;

429.18 (3) to persons authorized in writing by the client or the client's representative to
429.19 receive the information, including third-party payers; and

429.20 (4) to representatives of the commissioner authorized to survey or investigate home
429.21 care providers under this chapter or federal laws.

429.22 Subd. 2. **Access to records.** The home care provider must ensure that the
429.23 appropriate records are readily available to employees or contractors authorized to access
429.24 the records. Client records must be maintained in a manner that allows for timely access,
429.25 printing, or transmission of the records.

429.26 Subd. 3. **Contents of client record.** Contents of a client record include the
429.27 following for each client:

429.28 (1) identifying information, including the client's name, date of birth, address, and
429.29 telephone number;

429.30 (2) the name, address, and telephone number of an emergency contact, family
429.31 members, client's representative, if any, or others as identified;

429.32 (3) names, addresses, and telephone numbers of the client's health and medical
429.33 service providers and other home care providers, if known;

429.34 (4) health information, including medical history, allergies, and when the provider
429.35 is managing medications, treatments or therapies that require documentation, and other
429.36 relevant health records;

430.1 (5) client's advance directives, if any;
430.2 (6) the home care provider's current and previous assessments and service plans;
430.3 (7) all records of communications pertinent to the client's home care services;
430.4 (8) documentation of significant changes in the client's status and actions taken in
430.5 response to the needs of the client including reporting to the appropriate supervisor or
430.6 health care professional;
430.7 (9) documentation of incidents involving the client and actions taken in response
430.8 to the needs of the client including reporting to the appropriate supervisor or health
430.9 care professional;
430.10 (10) documentation that services have been provided as identified in the service plan;
430.11 (11) documentation that the client has received and reviewed the home care bill
430.12 of rights;
430.13 (12) documentation that the client has been provided the statement of disclosure on
430.14 limitations of services under section 144A.4791, subdivision 3;
430.15 (13) documentation of complaints received and resolution;
430.16 (14) discharge summary, including service termination notice and related
430.17 documentation, when applicable; and
430.18 (15) other documentation required under this chapter and relevant to the client's
430.19 services or status.
430.20 Subd. 4. **Transfer of client records.** If a client transfers to another home care
430.21 provider or other health care practitioner or provider, or is admitted to an inpatient facility,
430.22 the home care provider, upon request of the client or the client's representative, shall take
430.23 steps to ensure a coordinated transfer including sending a copy or summary of the client's
430.24 record to the new home care provider, facility, or the client, as appropriate.
430.25 Subd. 5. **Record retention.** Following the client's discharge or termination of
430.26 services, a home care provider must retain a client's record for at least five years, or as
430.27 otherwise required by state or federal regulations. Arrangements must be made for secure
430.28 storage and retrieval of client records if the home care provider ceases business.

430.29 Sec. 21. **[144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.**
430.30 Subdivision 1. **Qualifications, training, and competency.** All staff providing
430.31 home care services must be trained and competent in the provision of home care services
430.32 consistent with current practice standards appropriate to the client's needs.
430.33 Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health
430.34 professionals and nurses providing home care services as an employee of a licensed home
430.35 care provider must possess current Minnesota license or registration to practice.

431.1 (b) Licensed health professionals and registered nurses must be competent in
431.2 assessing client needs, planning appropriate home care services to meet client needs,
431.3 implementing services, and supervising staff if assigned.

431.4 (c) Nothing in this section limits or expands the rights of nurses or licensed health
431.5 professionals to provide services within the scope of their licenses or registrations, as
431.6 provided by law.

431.7 Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home
431.8 care services must have:

431.9 (1) successfully completed a training and competency evaluation appropriate to
431.10 the services provided by the home care provider and the topics listed in subdivision 7,
431.11 paragraph (b); or

431.12 (2) demonstrated competency by satisfactorily completing a written or oral test on
431.13 the tasks the unlicensed personnel will perform and in the topics listed in subdivision
431.14 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7,
431.15 paragraph (b), clauses (5), (7), and (8), by a practical skills test.

431.16 Unlicensed personnel providing home care services for a basic home care provider may
431.17 not perform delegated nursing or therapy tasks.

431.18 (b) Unlicensed personnel performing delegated nursing tasks for a comprehensive
431.19 home care provider must have:

431.20 (1) successfully completed training and demonstrated competency by successfully
431.21 completing a written or oral test of the topics in subdivision 7, paragraphs (b) and (c), and
431.22 a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5) and (7),
431.23 and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; or

431.24 (2) satisfy the current requirements of Medicare for training or competency of home
431.25 health aides or nursing assistants, as provided by Code of Federal Regulations, title 42,
431.26 section 483 or section 484.36; or

431.27 (3) before April 19, 1993, completed a training course for nursing assistants that was
431.28 approved by the commissioner.

431.29 (c) Unlicensed personnel performing therapy or treatment tasks delegated or
431.30 assigned by a licensed health professional must meet the requirements for delegated
431.31 tasks in subdivision 4 and any other training or competency requirements within the
431.32 licensed health professional scope of practice relating to delegation or assignment of tasks
431.33 to unlicensed personnel.

431.34 Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health
431.35 professional may delegate tasks only to staff that are competent and possess the knowledge
431.36 and skills consistent with the complexity of the tasks and according to the appropriate

432.1 Minnesota Practice Act. The comprehensive home care provider must establish and
432.2 implement a system to communicate up-to-date information to the registered nurse or
432.3 licensed health professional regarding the current available staff and their competency so
432.4 the registered nurse or licensed health professional has sufficient information to determine
432.5 the appropriateness of delegating tasks to meet individual client needs and preferences.

432.6 Subd. 5. **Individual contractors.** When a home care provider contracts with an
432.7 individual contractor excluded from licensure under section 144A.471 to provide home
432.8 care services, the contractor must meet the same requirements required by this section for
432.9 personnel employed by the home care provider.

432.10 Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary
432.11 staffing agency excluded from licensure under section 144A.471, those individuals must
432.12 meet the same requirements required by this section for personnel employed by the home
432.13 care provider and shall be treated as if they are staff of the home care provider.

432.14 Subd. 7. **Requirements for instructors, training content, and competency**
432.15 **evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must
432.16 meet the following requirements:

432.17 (1) training and competency evaluations of unlicensed personnel providing basic
432.18 home care services must be conducted by individuals with work experience and training in
432.19 providing home care services listed in section 144A.471, subdivisions 6 and 7; and

432.20 (2) training and competency evaluations of unlicensed personnel providing
432.21 comprehensive home care services must be conducted by a registered nurse, or another
432.22 instructor may provide training in conjunction with the registered nurse. If the home care
432.23 provider is providing services by licensed health professionals only, then that specific
432.24 training and competency evaluation may be conducted by the licensed health professionals
432.25 as appropriate.

432.26 (b) Training and competency evaluations for all unlicensed personnel must include
432.27 the following:

432.28 (1) documentation requirements for all services provided;

432.29 (2) reports of changes in the client's condition to the supervisor designated by the
432.30 home care provider;

432.31 (3) basic infection control, including blood-borne pathogens;

432.32 (4) maintenance of a clean and safe environment;

432.33 (5) appropriate and safe techniques in personal hygiene and grooming, including:

432.34 (i) hair care and bathing;

432.35 (ii) care of teeth, gums, and oral prosthetic devices;

432.36 (iii) care and use of hearing aids; and

433.1 (iv) dressing and assisting with toileting;
433.2 (6) training on the prevention of falls for providers working with the elderly or
433.3 individuals at risk of falls;
433.4 (7) standby assistance techniques and how to perform them;
433.5 (8) medication, exercise, and treatment reminders;
433.6 (9) basic nutrition, meal preparation, food safety, and assistance with eating;
433.7 (10) preparation of modified diets as ordered by a licensed health professional;
433.8 (11) communication skills that include preserving the dignity of the client and
433.9 showing respect for the client and the client's preferences, cultural background, and family;
433.10 (12) awareness of confidentiality and privacy;
433.11 (13) understanding appropriate boundaries between staff and clients and the client's
433.12 family;
433.13 (14) procedures to utilize in handling various emergency situations; and
433.14 (15) awareness of commonly used health technology equipment and assistive devices.
433.15 (c) In addition to paragraph (b), training and competency evaluation for unlicensed
433.16 personnel providing comprehensive home care services must include:
433.17 (1) observation, reporting, and documenting of client status;
433.18 (2) basic knowledge of body functioning and changes in body functioning, injuries,
433.19 or other observed changes that must be reported to appropriate personnel;
433.20 (3) reading and recording temperature, pulse, and respirations of the client;
433.21 (4) recognizing physical, emotional, cognitive, and developmental needs of the client;
433.22 (5) safe transfer techniques and ambulation;
433.23 (6) range of motioning and positioning; and
433.24 (7) administering medications or treatments as required.
433.25 (d) When the registered nurse or licensed health professional delegates tasks, they
433.26 must ensure that prior to the delegation the unlicensed personnel is trained in the proper
433.27 methods to perform the tasks or procedures for each client and are able to demonstrate
433.28 the ability to competently follow the procedures and perform the tasks. If an unlicensed
433.29 personnel has not regularly performed the delegated home care task for a period of 24
433.30 consecutive months, the unlicensed personnel must demonstrate competency in the task
433.31 to the registered nurse or appropriate licensed health professional. The registered nurse
433.32 or licensed health professional must document instructions for the delegated tasks in
433.33 the client's record.

433.34 Sec. 22. **[144A.4796] ORIENTATION AND ANNUAL TRAINING**
433.35 **REQUIREMENTS.**

434.1 Subdivision 1. **Orientation of staff and supervisors to home care.** All staff
434.2 providing and supervising direct home care services must complete an orientation to home
434.3 care licensing requirements and regulations before providing home care services to clients.
434.4 The orientation may be incorporated into the training required under subdivision 6. The
434.5 orientation need only be completed once for each staff person and is not transferable
434.6 to another home care provider.

434.7 Subd. 2. **Content.** The orientation must contain the following topics:

434.8 (1) an overview of sections 144A.43 to 144A.4798;

434.9 (2) introduction and review of all the provider's policies and procedures related to
434.10 the provision of home care services;

434.11 (3) handling of emergencies and use of emergency services;

434.12 (4) compliance with and reporting the maltreatment of minors or vulnerable adults
434.13 under sections 626.556 and 626.557;

434.14 (5) home care bill of rights, under section 144A.44;

434.15 (6) handling of clients' complaints; reporting of complaints and where to report
434.16 complaints including information on the Office of Health Facility Complaints and the
434.17 Common Entry Point;

434.18 (7) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
434.19 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
434.20 Ombudsman at the Department of Human Services, county managed care advocates,
434.21 or other relevant advocacy services; and

434.22 (8) review of the types of home care services the employee will be providing and
434.23 the provider's scope of licensure.

434.24 Subd. 3. **Verification and documentation of orientation.** Each home care provider
434.25 shall retain evidence in the employee record of each staff person having completed the
434.26 orientation required by this section.

434.27 Subd. 4. **Orientation to client.** Staff providing home care services must be oriented
434.28 specifically to each individual client and the services to be provided. This orientation may
434.29 be provided in person, orally, in writing, or electronically.

434.30 Subd. 5. **Training required relating to Alzheimer's disease and related**
434.31 **disorders.** For home care providers that market, promote, or provide services for persons
434.32 with Alzheimer's or related disorders, all direct care staff and their supervisors must
434.33 receive training that includes a current explanation of Alzheimer's disease and related
434.34 disorders, how to assist clients with activities of daily living, effective approaches to
434.35 use to problem solve when working with a client's challenging behaviors, and how to
434.36 communicate with clients who have Alzheimer's or related disorders.

435.1 Subd. 6. **Required annual training.** All staff that perform direct home care
435.2 services must complete at least eight hours of annual training for each 12 months of
435.3 employment. The training may be obtained from the home care provider or another source
435.4 and must include topics relevant to the provision of home care services. The annual
435.5 training must include:

435.6 (1) training on reporting of maltreatment of minors under section 626.556 and
435.7 maltreatment of vulnerable adults under section 626.557, whichever is applicable to the
435.8 services provided;

435.9 (2) review of the home care bill of rights in section 144A.44;

435.10 (3) review of infection control techniques used in the home and implementation of
435.11 infection control standards including a review of hand washing techniques; the need for
435.12 and use of protective gloves, gowns, and masks; appropriate disposal of contaminated
435.13 materials and equipment, such as dressings, needles, syringes, and razor blades;
435.14 disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of
435.15 communicable diseases; and

435.16 (4) review of the provider's policies and procedures relating to the provision of home
435.17 care services and how to implement those policies and procedures.

435.18 Subd. 7. **Documentation.** A home care provider must retain documentation in the
435.19 employee records of the staff that have satisfied the orientation and training requirements
435.20 of this section.

435.21 Sec. 23. **[144A.4797] PROVISION OF SERVICES.**

435.22 Subdivision 1. **Availability of contact person to staff.** (a) A home care provider
435.23 with a basic home care license must have a person available to staff for consultation on
435.24 items relating to the provision of services or about the client.

435.25 (b) A home care provider with a comprehensive home care license must have a
435.26 registered nurse available for consultation to staff performing delegated nursing tasks
435.27 and must have an appropriate licensed health professional available if performing other
435.28 delegated services such as therapies.

435.29 (c) The appropriate contact person must be readily available either in person, by
435.30 telephone, or by other means to the staff at times when the staff is providing services.

435.31 Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform
435.32 basic home care services must be supervised periodically where the services are being
435.33 provided to verify that the work is being performed competently and to identify problems
435.34 and solutions to address issues relating to the staff's ability to provide the services. The
435.35 supervision of the unlicensed personnel must be done by staff of the home care provider

436.1 having the authority, skills, and ability to provide the supervision of unlicensed personnel
436.2 and who can implement changes as needed, and train staff.

436.3 (b) Supervision includes direct observation of unlicensed personnel while they
436.4 are providing the services and may also include indirect methods of gaining input such
436.5 as gathering feedback from the client. Supervisory review of staff must be provided at a
436.6 frequency based on the staff person's competency and performance.

436.7 (c) For an individual who is licensed as a home care provider, this section does
436.8 not apply.

436.9 Subd. 3. **Supervision of staff providing delegated nursing or therapy home**
436.10 **care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be
436.11 supervised by an appropriate licensed health professional or a registered nurse periodically
436.12 where the services are being provided to verify that the work is being performed
436.13 competently and to identify problems and solutions related to the staff person's ability to
436.14 perform the tasks. Supervision of staff performing medication or treatment administration
436.15 shall be provided by a registered nurse or appropriate licensed health professional and
436.16 must include observation of the staff administering the medication or treatment and the
436.17 interaction with the client.

436.18 (b) The direct supervision of staff performing delegated tasks must be provided
436.19 within 30 days after the individual begins working for the home care provider and
436.20 thereafter as needed based on performance. This requirement also applies to staff who
436.21 have not performed delegated tasks for one year or longer.

436.22 Subd. 4. **Documentation.** A home care provider must retain documentation of
436.23 supervision activities in the personnel records.

436.24 Subd. 5. **Exemption.** This section does not apply to an individual licensed under
436.25 sections 144A.43 to 144A.4799.

436.26 Sec. 24. **[144A.4798] EMPLOYEE HEALTH STATUS.**

436.27 Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider
436.28 must establish and maintain a TB prevention and control program based on the most
436.29 current guidelines issued by the Centers for Disease Control and Prevention (CDC).
436.30 Components of a TB prevention and control program include screening all staff providing
436.31 home care services, both paid and unpaid, at the time of hire for active TB disease and
436.32 latent TB infection, and developing and implementing a written TB infection control plan.
436.33 The commissioner shall make the most recent CDC standards available to home care
436.34 providers on the department's Web site.

437.1 Subd. 2. **Communicable diseases.** A home care provider must follow
437.2 current federal or state guidelines for prevention, control, and reporting of human
437.3 immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other
437.4 communicable diseases as defined in Minnesota Rules, part 4605.7040.

437.5 Sec. 25. **[144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE**
437.6 **PROVIDER ADVISORY COUNCIL.**

437.7 Subdivision 1. **Membership.** The commissioner of health shall appoint eight
437.8 persons to a home care provider advisory council consisting of the following:
437.9 (1) three public members as defined in section 214.02 who shall be either persons
437.10 who are currently receiving home care services or have family members receiving home
437.11 care services, or persons who have family members who have received home care services
437.12 within five years of the application date;
437.13 (2) three Minnesota home care licensees representing basic and comprehensive
437.14 levels of licensure who may be a managerial official, an administrator, a supervising
437.15 registered nurse, or an unlicensed personnel performing home care tasks;
437.16 (3) one member representing the Minnesota Board of Nursing; and
437.17 (4) one member representing the ombudsman for long-term care.
437.18 Subd. 2. **Organizations and meetings.** The advisory council shall be organized
437.19 and administered under section 15.059 with per diems and costs paid within the limits of
437.20 available appropriations. Meetings will be held quarterly and hosted by the department.
437.21 Subcommittees may be developed as necessary by the commissioner. Advisory council
437.22 meetings are subject to the Open Meeting Law under chapter 13D.
437.23 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide
437.24 advice regarding regulations of Department of Health licensed home care providers in
437.25 this chapter such as:
437.26 (1) advice to the commissioner regarding community standards for home care
437.27 practices;
437.28 (2) advice to the commissioner on enforcement of licensing standards and whether
437.29 certain disciplinary actions are appropriate;
437.30 (3) advice to the commissioner about ways of distributing information to licensees
437.31 and consumers of home care;
437.32 (4) advice to the commissioner about training standards;
437.33 (5) identify emerging issues and opportunities in the home care field, including the
437.34 use of technology in home and telehealth capabilities; and
437.35 (6) perform other duties as directed by the commissioner.

438.1 Sec. 26. **[144A.481] HOME CARE LICENSING IMPLEMENTATION FOR**
438.2 **NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**
438.3 Subdivision 1. **Initial home care licenses and changes of ownership.** (a)
438.4 Beginning October 1, 2013, all initial license applicants must apply for either a temporary
438.5 basic or comprehensive home care license.
438.6 (b) Initial home care temporary licenses or licenses issued beginning October 1,
438.7 2013, will be issued according to the provisions in sections 144A.43 to 144A.4799 and
438.8 fees in section 144A.472 and will be required to comply with this chapter.
438.9 (c) No initial temporary licenses or initial licenses will be accepted or issued
438.10 between July 1, 2013, and October 1, 2013.
438.11 (d) Beginning July 1, 2013, changes in ownership applications will require payment
438.12 of the new fees listed in section 144A.472.
438.13 Subd. 2. **Current home care licensees with licenses on July 1, 2013.** (a)
438.14 Beginning October 1, 2013, department licensed home care providers who are licensed
438.15 on July 1, 2013, must apply for either the basic or comprehensive home care license
438.16 on their regularly scheduled renewal date.
438.17 (b) By September 30, 2014, all home care providers must either have a basic or
438.18 comprehensive home care license or temporary license.

438.19 Sec. 27. **[144A.4811] APPLICATION OF HOME CARE LICENSURE DURING**
438.20 **TRANSITION PERIOD.**
438.21 Renewal of home care licenses issued beginning October 1, 2013, will be issued
438.22 according to sections 144A.43 to 144A.4799 and, upon license renewal, providers must
438.23 comply with sections 144A.43 to 144A.4799. Prior to renewal, providers must comply
438.24 with the home care licensure law in effect on June 30, 2013.

438.25 Sec. 28. **[144A.482] REGISTRATION OF HOME MANAGEMENT**
438.26 **PROVIDERS.**
438.27 (a) For purposes of this section, a home management provider is an individual or
438.28 organization that provides at least two of the following services: housekeeping, meal
438.29 preparation, and shopping, to a person who is unable to perform these activities due to
438.30 illness, disability, or physical condition.
438.31 (b) A person or organization that provides only home management services may not
438.32 operate in the state without a current certificate of registration issued by the commissioner
438.33 of health. To obtain a certificate of registration, the person or organization must annually
438.34 submit to the commissioner the name, mailing and physical address, e-mail address, and

439.1 telephone number of the individual or organization and a signed statement declaring that
439.2 the individual or organization is aware that the home care bill of rights applies to their
439.3 clients and that the person or organization will comply with the home care bill of rights
439.4 provisions contained in section 144A.44. An individual or organization applying for a
439.5 certificate must also provide the name, business address, and telephone number of each of
439.6 the individuals responsible for the management or direction of the organization.

439.7 (c) The commissioner shall charge an annual registration fee of $20 for individuals
439.8 and $50 for organizations. The registration fee shall be deposited in the state treasury and
439.9 credited to the state government special revenue fund.

439.10 (d) A home care provider that provides home management services and other home
439.11 care services must be licensed, but licensure requirements other than the home care bill of
439.12 rights do not apply to those employees or volunteers who provide only home management
439.13 services to clients who do not receive any other home care services from the provider.
439.14 A licensed home care provider need not be registered as a home management service
439.15 provider, but must provide an orientation on the home care bill of rights to its employees
439.16 or volunteers who provide home management services.

439.17 (e) An individual who provides home management services under this section must,
439.18 within 120 days after beginning to provide services, attend an orientation session approved
439.19 by the commissioner that provides training on the home care bill of rights and an orientation
439.20 on the aging process and the needs and concerns of elderly and disabled persons.

439.21 (f) The commissioner may suspend or revoke a provider's certificate of registration
439.22 or assess fines for violation of the home care bill of rights. Any fine assessed for a
439.23 violation of the home care bill of rights by a provider registered under this section shall be
439.24 in the amount established in the licensure rules for home care providers. As a condition
439.25 of registration, a provider must cooperate fully with any investigation conducted by the
439.26 commissioner, including providing specific information requested by the commissioner on
439.27 clients served and the employees and volunteers who provide services. Fines collected
439.28 under this paragraph shall be deposited in the state treasury and credited to the fund
439.29 specified in the statute or rule in which the penalty was established.

439.30 (g) The commissioner may use any of the powers granted in sections 144A.43 to
439.31 144A.4799 to administer the registration system and enforce the home care bill of rights
439.32 under this section.

439.33 Sec. 29. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
439.34 **AND COMMUNITY-BASED SERVICES.**

440.1 (a) The Department of Health Compliance Monitoring Division and the Department
440.2 of Human Services Licensing Division shall jointly develop an integrated licensing system
440.3 for providers of both home care services subject to licensure under Minnesota Statutes,
440.4 chapter 144A, and for home and community-based services subject to licensure under
440.5 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

440.6 (1) require only one license of any provider of services under Minnesota Statutes,
440.7 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

440.8 (2) promote quality services that recognize a person's individual needs and protect
440.9 the person's health, safety, rights, and well-being;

440.10 (3) promote provider accountability through application requirements, compliance
440.11 inspections, investigations, and enforcement actions;

440.12 (4) reference other applicable requirements in existing state and federal laws,
440.13 including the federal Affordable Care Act;

440.14 (5) establish internal procedures to facilitate ongoing communications between the
440.15 agencies, and with providers and services recipients about the regulatory activities;

440.16 (6) create a link between the agency Web sites so that providers and the public can
440.17 access the same information regardless of which Web site is accessed initially; and

440.18 (7) collect data on identified outcome measures as necessary for the agencies to
440.19 report to the Centers for Medicare and Medicaid Services.

440.20 (b) The joint recommendations for legislative changes to implement the integrated
440.21 licensing system are due to the legislature by February 15, 2014.

440.22 (c) Before implementation of the integrated licensing system, providers licensed as
440.23 home care providers under Minnesota Statutes, chapter 144A, may also provide home
440.24 and community-based services subject to licensure under Minnesota Statutes, chapter
440.25 245D, without obtaining a home and community-based services license under Minnesota
440.26 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
440.27 apply to these providers:

440.28 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
440.29 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

440.30 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
440.31 enforced by the Department of Health under the enforcement authority set forth in
440.32 Minnesota Statutes, section 144A.475; and

440.33 (3) the Department of Health will provide information to the Department of Human
440.34 Services about each provider licensed under this section, including the provider's license
440.35 application, licensing documents, inspections, information about complaints received, and
440.36 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

441.1 Sec. 30. **REPEALER.**

441.2 (a) Minnesota Statutes 2012, sections 144A.46; and 144A.461, are repealed.

441.3 (b) Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008;
441.4 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040;
441.5 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
441.6 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170;
441.7 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240;
441.8 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830;
441.9 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870;
441.10 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; and 4669.0050, are repealed.

441.11 Sec. 31. **EFFECTIVE DATE.**

441.12 Sections 1 to 30 are effective the day following final enactment.

441.13 **ARTICLE 13**

441.14 **HEALTH DEPARTMENT**

441.15 Section 1. Minnesota Statutes 2012, section 103I.005, is amended by adding a
441.16 subdivision to read:

441.17 Subd. 1a. **Bored geothermal heat exchanger.** "Bored geothermal heat exchanger"
441.18 means an earth-coupled heating or cooling device consisting of a sealed closed-loop
441.19 piping system installed in a boring in the ground to transfer heat to or from the surrounding
441.20 earth with no discharge.

441.21 Sec. 2. Minnesota Statutes 2012, section 103I.521, is amended to read:

441.22 **103I.521 FEES ~~DEPOSITED WITH COMMISSIONER OF MANAGEMENT~~**
441.23 **~~AND BUDGET~~.**

441.24 Unless otherwise specified, fees collected ~~for licenses or registration~~ by the
441.25 commissioner under this chapter shall be deposited in the state treasury and credited to
441.26 the state government special revenue fund.

441.27 Sec. 3. Minnesota Statutes 2012, section 144.123, subdivision 1, is amended to read:

441.28 ~~Subdivision 1.~~ **~~Who must pay.~~** Except for the limitation contained in this section,
441.29 the commissioner of health ~~shall charge a handling fee~~ may enter into a contractual
441.30 agreement to recover costs incurred for analysis for diagnostic purposes for each specimen
441.31 submitted to the Department of Health ~~for analysis for diagnostic purposes~~ by any hospital,

442.1 private laboratory, private clinic, or physician. No fee shall be charged to any entity which
442.2 receives direct or indirect financial assistance from state or federal funds administered by
442.3 the Department of Health, including any public health department, nonprofit community
442.4 clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged The
442.5 commissioner shall not charge for any biological materials submitted to the Department
442.6 of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological
442.7 materials requested by the department to gather information for disease prevention or
442.8 control purposes. The commissioner of health may establish other exceptions to the
442.9 handling fee as may be necessary to protect the public's health. All fees collected pursuant
442.10 to this section shall be deposited in the state treasury and credited to the state government
442.11 special revenue fund. Funds generated in a contractual agreement made pursuant to this
442.12 section shall be deposited in a special account and are appropriated to the commissioner
442.13 for purposes of providing the services specified in the contracts. All such contractual
442.14 agreements shall be processed in accordance with the provisions of chapter 16C.

442.15 **EFFECTIVE DATE.** This section is effective July 1, 2014.

442.16 Sec. 4. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:
442.17 Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative
442.18 officer or other person in charge of each institution caring for infants 28 days or less
442.19 of age, (2) the person required in pursuance of the provisions of section 144.215, to
442.20 register the birth of a child, or (3) the nurse midwife or midwife in attendance at the
442.21 birth, to arrange to have administered to every infant or child in its care tests for heritable
442.22 and congenital disorders according to subdivision 2 and rules prescribed by the state
442.23 commissioner of health.
442.24 (b) Testing and the, recording and of test results, reporting of test results, and
442.25 follow-up of infants with heritable congenital disorders, including hearing loss detected
442.26 through the early hearing detection and intervention program in section 144.966, shall be
442.27 performed at the times and in the manner prescribed by the commissioner of health. The
442.28 commissioner shall charge a fee so that the total of fees collected will approximate the
442.29 costs of conducting the tests and implementing and maintaining a system to follow-up
442.30 infants with heritable or congenital disorders, including hearing loss detected through the
442.31 early hearing detection and intervention program under section 144.966.
442.32 (c) The fee is $101 per specimen. Effective July 1, 2010, the fee shall be increased
442.33 to $106 to support the newborn screening program, including tests administered under
442.34 this section and section 144.966, shall be $135 per specimen. The increased fee amount
442.35 shall be deposited in the general fund. Costs associated with capital expenditures and

443.1 ~~the development of new procedures may be prorated over a three-year period when~~
443.2 ~~calculating the amount of the fees.~~ This fee amount shall be deposited in the state treasury
443.3 and credited to the state government special revenue fund.

443.4 (d) The fee to offset the cost of the support services provided under section 144.966,
443.5 subdivision 3a, shall be $5 per specimen. This fee shall be deposited in the state treasury
443.6 and credited to the general fund.

443.7 Sec. 5. **[144.554] HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL**
443.8 **AND FEES.**

443.9 For hospitals, nursing homes, boarding care homes, residential hospices, supervised
443.10 living facilities, freestanding outpatient surgical centers, and end-stage renal disease
443.11 facilities, the commissioner shall collect a fee for the review and approval of architectural,
443.12 mechanical, and electrical plans and specifications submitted before construction begins
443.13 for each project relative to construction of new buildings, additions to existing buildings,
443.14 or for remodeling or alterations of existing buildings. All fees collected in this section
443.15 shall be deposited in the state treasury and credited to the state government special revenue
443.16 fund. Fees must be paid at the time of submission of final plans for review and are not
443.17 refundable. The fee is calculated as follows:

	Construction project total estimated cost	Fee
443.18		
443.19	$0 - $10,000	$30
443.20	$10,001 - $50,000	$150
443.21	$50,001 - $100,000	$300
443.22	$100,001 - $150,000	$450
443.23	$150,001 - $200,000	$600
443.24	$200,001 - $250,000	$750
443.25	$250,001 - $300,000	$900
443.26	$300,001 - $350,000	$1,050
443.27	$350,001 - $400,000	$1,200
443.28	$400,001 - $450,000	$1,350
443.29	$450,001 - $500,000	$1,500
443.30	$500,001 - $550,000	$1,650
443.31	$550,001 - $600,000	$1,800
443.32	$600,001 - $650,000	$1,950
443.33	$650,001 - $700,000	$2,100
443.34	$700,001 - $750,000	$2,250
443.35	$750,001 - $800,000	$2,400
443.36	$800,001 - $850,000	$2,550
443.37	$850,001 - $900,000	$2,700
443.38	$900,001 - $950,000	$2,850
443.39	$950,001 - $1,000,000	$3,000

444.1 $1,000,001 - $1,050,000	$3,150
444.2 $1,050,001 - $1,100,000	$3,300
444.3 $1,100,001 - $1,150,000	$3,450
444.4 $1,150,001 - $1,200,000	$3,600
444.5 $1,200,001 - $1,250,000	$3,750
444.6 $1,250,001 - $1,300,000	$3,900
444.7 $1,300,001 - $1,350,000	$4,050
444.8 $1,350,001 - $1,400,000	$4,200
444.9 $1,400,001 - $1,450,000	$4,350
444.10 $1,450,001 - $1,500,000	$4,500
444.11 $1,500,001 and over	$4,800

444.12 Sec. 6. Minnesota Statutes 2012, section 144.966, subdivision 2, is amended to read:
444.13 Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The
444.14 commissioner of health shall establish a Newborn Hearing Screening Advisory Committee
444.15 to advise and assist the Department of Health and the Department of Education in:
444.16 (1) developing protocols and timelines for screening, rescreening, and diagnostic
444.17 audiological assessment and early medical, audiological, and educational intervention
444.18 services for children who are deaf or hard-of-hearing;
444.19 (2) designing protocols for tracking children from birth through age three that may
444.20 have passed newborn screening but are at risk for delayed or late onset of permanent
444.21 hearing loss;
444.22 (3) designing a technical assistance program to support facilities implementing the
444.23 screening program and facilities conducting rescreening and diagnostic audiological
444.24 assessment;
444.25 (4) designing implementation and evaluation of a system of follow-up and tracking;
444.26 and
444.27 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
444.28 culturally appropriate services for children with a confirmed hearing loss and their families.
444.29 (b) The commissioner of health shall appoint at least one member from each of the
444.30 following groups with no less than two of the members being deaf or hard-of-hearing:
444.31 (1) a representative from a consumer organization representing culturally deaf
444.32 persons;
444.33 (2) a parent with a child with hearing loss representing a parent organization;
444.34 (3) a consumer from an organization representing oral communication options;
444.35 (4) a consumer from an organization representing cued speech communication
444.36 options;

445.1 (5) an audiologist who has experience in evaluation and intervention of infants
445.2 and young children;
445.3 (6) a speech-language pathologist who has experience in evaluation and intervention
445.4 of infants and young children;
445.5 (7) two primary care providers who have experience in the care of infants and young
445.6 children, one of which shall be a pediatrician;
445.7 (8) a representative from the early hearing detection intervention teams;
445.8 (9) a representative from the Department of Education resource center for the deaf
445.9 and hard-of-hearing or the representative's designee;
445.10 (10) a representative of the Commission of Deaf, DeafBlind and Hard-of-Hearing
445.11 Minnesotans;
445.12 (11) a representative from the Department of Human Services Deaf and
445.13 Hard-of-Hearing Services Division;
445.14 (12) one or more of the Part C coordinators from the Department of Education, the
445.15 Department of Health, or the Department of Human Services or the department's designees;
445.16 (13) the Department of Health early hearing detection and intervention coordinators;
445.17 (14) two birth hospital representatives from one rural and one urban hospital;
445.18 (15) a pediatric geneticist;
445.19 (16) an otolaryngologist;
445.20 (17) a representative from the Newborn Screening Advisory Committee under
445.21 this subdivision; and
445.22 (18) a representative of the Department of Education regional low-incidence
445.23 facilitators.

445.24 The commissioner must complete the appointments required under this subdivision by
445.25 September 1, 2007.
445.26 (c) The Department of Health member shall chair the first meeting of the committee.
445.27 At the first meeting, the committee shall elect a chair from its membership. The committee
445.28 shall meet at the call of the chair, at least four times a year. The committee shall adopt
445.29 written bylaws to govern its activities. The Department of Health shall provide technical
445.30 and administrative support services as required by the committee. These services shall
445.31 include technical support from individuals qualified to administer infant hearing screening,
445.32 rescreening, and diagnostic audiological assessments.
445.33 Members of the committee shall receive no compensation for their service, but
445.34 shall be reimbursed as provided in section 15.059 for expenses incurred as a result of
445.35 their duties as members of the committee.
445.36 (d) This subdivision expires June 30, ~~2013~~ <u>2019</u>.

446.1 Sec. 7. Minnesota Statutes 2012, section 144.98, subdivision 3, is amended to read:

446.2 Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must
446.3 be accompanied by the annual fees specified in this subdivision. The annual fees include:

446.4 (1) base accreditation fee, ~~$1,500~~ $600;

446.5 (2) sample preparation techniques fee, $200 per technique;

446.6 (3) an administrative fee for laboratories located outside this state, ~~$3,750~~ $2,000; and

446.7 (4) test category fees.

446.8 (b) For the programs in subdivision 3a, the commissioner may accredit laboratories
446.9 for fields of testing under the categories listed in clauses (1) to (10) upon completion of
446.10 the application requirements provided by subdivision 6 and receipt of the fees for each
446.11 category under each program that accreditation is requested. The categories offered and
446.12 related fees include:

446.13 (1) microbiology, ~~$450~~ $200;

446.14 (2) inorganics, ~~$450~~ $200;

446.15 (3) metals, ~~$1,000~~ $500;

446.16 (4) volatile organics, ~~$1,300~~ $1,000;

446.17 (5) other organics, ~~$1,300~~ $1,000;

446.18 (6) radiochemistry, ~~$1,500~~ $750;

446.19 (7) emerging contaminants, ~~$1,500~~ $1,000;

446.20 (8) agricultural contaminants, ~~$1,250~~ $1,000;

446.21 (9) toxicity (bioassay), ~~$1,000~~ $500; and

446.22 (10) physical characterization, $250.

446.23 (c) The total annual fee includes the base fee, the sample preparation techniques
446.24 fees, the test category fees per program, and, when applicable, an administrative fee for
446.25 out-of-state laboratories.

446.26 **EFFECTIVE DATE.** This section is effective the day following final enactment.

446.27 Sec. 8. Minnesota Statutes 2012, section 144.98, subdivision 5, is amended to read:

446.28 Subd. 5. **State government special revenue fund.** Fees collected by the
446.29 commissioner under this section must be deposited in the state treasury and credited to
446.30 the state government special revenue fund.

446.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

446.32 Sec. 9. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
446.33 to read:

447.1 Subd. 10. **Establishing a selection committee.** (a) The commissioner shall
447.2 establish a selection committee for the purpose of recommending approval of qualified
447.3 laboratory assessors and assessment bodies. Committee members shall demonstrate
447.4 competence in assessment practices. The committee shall initially consist of seven
447.5 members appointed by the commissioner as follows:

447.6 (1) one member from a municipal laboratory accredited by the commissioner;

447.7 (2) one member from an industrial treatment laboratory accredited by the
447.8 commissioner;

447.9 (3) one member from a commercial laboratory located in this state and accredited by
447.10 the commissioner;

447.11 (4) one member from a commercial laboratory located outside the state and
447.12 accredited by the commissioner;

447.13 (5) one member from a nongovernmental client of environmental laboratories;

447.14 (6) one member from a professional organization with a demonstrated interest in
447.15 environmental laboratory data and accreditation; and

447.16 (7) one employee of the laboratory accreditation program administered by the
447.17 department.

447.18 (b) Committee appointments begin on January 1 and end on December 31 of the
447.19 same year.

447.20 (c) The commissioner shall appoint persons to fill vacant committee positions,
447.21 expand the total number of appointed positions, or change the designated positions upon
447.22 the advice of the committee.

447.23 (d) The commissioner shall rescind the appointment of a selection committee
447.24 member for sufficient cause as the commissioner determines, such as:

447.25 (1) neglect of duty;

447.26 (2) failure to notify the commissioner of a real or perceived conflict of interest;

447.27 (3) nonconformance with committee procedures;

447.28 (4) failure to demonstrate competence in assessment practices; or

447.29 (5) official misconduct.

447.30 (e) Members of the selection committee shall be compensated according to the
447.31 provisions in section 15.059, subdivision 3.

447.32 Sec. 10. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
447.33 to read:

447.34 Subd. 11. **Activities of the selection committee.** (a) The selection committee
447.35 will determine assessor and assessment body application requirements, the frequency

448.1 of application submittal, and the application review schedule. The commissioner shall
448.2 publish the application requirements and procedures on the accreditation program Web site.
448.3 (b) In its selection process, the committee shall ensure its application requirements
448.4 and review process:
448.5 (1) meet the standards implemented in subdivision 2a;
448.6 (2) ensure assessors have demonstrated competence in technical disciplines offered
448.7 for accreditation by the commissioner; and
448.8 (3) consider any history of repeated nonconformance or complaints regarding
448.9 assessors or assessment bodies.
448.10 (c) The selection committee shall consider an application received from qualified
448.11 applicants and shall supply a list of recommended assessors and assessment bodies to
448.12 the commissioner of health no later than 90 days after the commissioner notifies the
448.13 committee of the need for review of applications.

448.14 Sec. 11. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
448.15 to read:
448.16 Subd. 12. **Commissioner approval of assessors and scheduling of assessments.**
448.17 (a) The commissioner shall approve assessors who:
448.18 (1) are employed by the commissioner for the purpose of accrediting laboratories
448.19 and demonstrate competence in assessment practices for environmental laboratories; or
448.20 (2) are employed by a state or federal agency with established agreements for
448.21 mutual assistance or recognition with the commissioner and demonstrate competence in
448.22 assessment practices for environmental laboratories.
448.23 (b) The commissioner may approve other assessors or assessment bodies who are
448.24 recommended by the selection committee according to subdivision 11, paragraph (c). The
448.25 commissioner shall publish the list of assessors and assessment bodies approved from the
448.26 recommendations.
448.27 (c) The commissioner shall rescind approval for an assessor or assessment body for
448.28 sufficient cause as the commissioner determines, such as:
448.29 (1) failure to meet the minimum qualifications for performing assessments;
448.30 (2) lack of availability;
448.31 (3) nonconformance with the applicable laws, rules, standards, policies, and
448.32 procedures;
448.33 (4) misrepresentation of application information regarding qualifications and
448.34 training; or
448.35 (5) excessive cost to perform the assessment activities.

449.1 Sec. 12. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
449.2 to read:

449.3 Subd. 13. **Laboratory requirements for assessor selection and scheduling**
449.4 **assessments.** (a) A laboratory accredited or seeking accreditation that requires an
449.5 assessment by the commissioner must select an assessor, group of assessors, or an
449.6 assessment body from the published list specified in subdivision 12, paragraph (b). An
449.7 accredited laboratory must complete an assessment and make all corrective actions at least
449.8 once every 24 months. Unless the commissioner grants interim accreditation, a laboratory
449.9 seeking accreditation must complete an assessment and make all corrective actions
449.10 prior to, but no earlier than, 18 months prior to the date the application is submitted to
449.11 the commissioner.

449.12 (b) A laboratory shall not select the same assessor more than twice in succession
449.13 for assessments of the same facility unless the laboratory receives written approval
449.14 from the commissioner for the selection. The laboratory must supply a written request
449.15 to the commissioner for approval and must justify the reason for the request and provide
449.16 the alternate options considered.

449.17 (c) A laboratory must select assessors appropriate to the size and scope of the
449.18 laboratory's application or existing accreditation.

449.19 (d) A laboratory must enter into its own contract for direct payment of the assessors
449.20 or assessment body. The contract must authorize the assessor, assessment body, or
449.21 subcontractors to release all records to the commissioner regarding the assessment activity,
449.22 when the assessment is performed in compliance with this statute.

449.23 (e) A laboratory must agree to permit other assessors as selected by the commissioner
449.24 to participate in the assessment activities.

449.25 (f) If the laboratory determines no approved assessor is available to perform
449.26 the assessment, the laboratory must notify the commissioner in writing and provide a
449.27 justification for the determination. If the commissioner confirms no approved assessor
449.28 is available, the commissioner may designate an alternate assessor from those approved
449.29 in subdivision 12, paragraph (a), or the commissioner may delay the assessment until
449.30 an assessor is available. If an approved alternate assessor performs the assessment, the
449.31 commissioner may collect fees equivalent to the cost of performing the assessment
449.32 activities.

449.33 (g) Fees collected under this section are deposited in a special account and are
449.34 annually appropriated to the commissioner for the purpose of performing assessment
449.35 activities.

449.36 **EFFECTIVE DATE.** This section is effective the day following final enactment.

450.1 Sec. 13. Minnesota Statutes 2012, section 144.99, subdivision 4, is amended to read:
450.2 Subd. 4. **Administrative penalty orders.** (a) The commissioner may issue an
450.3 order requiring violations to be corrected and administratively assessing monetary
450.4 penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The
450.5 procedures in section 144.991 must be followed when issuing administrative penalty
450.6 orders. Except in the case of repeated or serious violations, the penalty assessed in the
450.7 order must be forgiven if the person who is subject to the order demonstrates in writing
450.8 to the commissioner before the 31st day after receiving the order that the person has
450.9 corrected the violation or has developed a corrective plan acceptable to the commissioner.
450.10 The maximum amount of an administrative penalty order is $10,000 for each violator for
450.11 all violations by that violator identified in an inspection or review of compliance.
450.12 (b) Notwithstanding paragraph (a), the commissioner may issue to a large public
450.13 water supply, serving a population of more than 10,000 persons, an administrative penalty
450.14 order imposing a penalty of at least $1,000 per day per violation, not to exceed $10,000
450.15 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.
450.16 (c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead
450.17 firm or person performing regulated lead work, an administrative penalty order imposing a
450.18 penalty of at least $5,000 per violation per day, not to exceed $10,000 for each violation of
450.19 sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from
450.20 monetary penalties in this section shall be deposited in the state treasury and credited to
450.21 the state government special revenue fund.

450.22 Sec. 14. Minnesota Statutes 2012, section 145.986, is amended to read:

450.23 **145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

450.24 Subdivision 1. ~~**Grants to local communities**~~ **Purpose.** The purpose of the statewide
450.25 health improvement program is to:
450.26 (1) address the top three leading preventable causes of illness and death: tobacco use
450.27 and exposure, poor diet, and lack of regular physical activity;
450.28 (2) promote the development, availability, and use of evidence-based, community
450.29 level, comprehensive strategies to create healthy communities; and
450.30 (3) measure the impact of the evidence-based, community health improvement
450.31 practices which over time work to contain health care costs and reduce chronic diseases.
450.32 Subd. 1a. **Grants to local communities.** (a) Beginning July 1, 2009, the
450.33 commissioner of health shall award competitive grants to community health boards
450.34 established pursuant to section 145A.09 and tribal governments to convene, coordinate,

451.1 and implement evidence-based strategies targeted at reducing the percentage of
451.2 Minnesotans who are obese or overweight and to reduce the use of tobacco.
451.3 (b) Grantee activities shall:
451.4 (1) be based on scientific evidence;
451.5 (2) be based on community input;
451.6 (3) address behavior change at the individual, community, and systems levels;
451.7 (4) occur in community, school, worksite, and health care settings; ~~and~~
451.8 (5) be focused on policy, systems, and environmental changes that support healthy
451.9 behaviors~~.~~; and
451.10 (6) address the health disparities and inequities that exist in the grantee's community.
451.11 (c) To receive a grant under this section, community health boards and tribal
451.12 governments must submit proposals to the commissioner. A local match of ten percent
451.13 of the total funding allocation is required. This local match may include funds donated
451.14 by community partners.
451.15 (d) In order to receive a grant, community health boards and tribal governments
451.16 must submit a health improvement plan to the commissioner of health for approval. The
451.17 commissioner may require the plan to identify a community leadership team, community
451.18 partners, and a community action plan that includes an assessment of area strengths and
451.19 needs, proposed action strategies, technical assistance needs, and a staffing plan.
451.20 (e) The grant recipient must implement the health improvement plan, evaluate the
451.21 effectiveness of the ~~interventions~~ strategies, and modify or discontinue ~~interventions~~
451.22 strategies found to be ineffective.
451.23 ~~(f) By January 15, 2011, the commissioner of health shall recommend whether any~~
451.24 ~~funding should be distributed to community health boards and tribal governments based~~
451.25 ~~on health disparities demonstrated in the populations served.~~
451.26 ~~(g)~~ (f) Grant recipients shall report their activities and their progress toward the
451.27 outcomes established under subdivision 2 to the commissioner in a format and at a time
451.28 specified by the commissioner.
451.29 ~~(h)~~ (g) All grant recipients shall be held accountable for making progress toward
451.30 the measurable outcomes established in subdivision 2. The commissioner shall require a
451.31 corrective action plan and may reduce the funding level of grant recipients that do not
451.32 make adequate progress toward the measurable outcomes.
451.33 (h) Notwithstanding paragraph (a), the commissioner may award funding to
451.34 convene, coordinate, and implement evidence-based strategies targeted at reducing other
451.35 risk factors, aside from tobacco use and exposure, poor diet, and lack of regular physical

452.1 activity, that are associated with chronic disease and may impact public health. The
452.2 commissioner shall develop a criteria and procedures to allocate funding under this section.

452.3 Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet
452.4 the goals specified in subdivision 1, and annually review the progress of grant recipients
452.5 in meeting the outcomes.

452.6 (b) The commissioner shall measure current public health status, using existing
452.7 measures and data collection systems when available, to determine baseline data against
452.8 which progress shall be monitored.

452.9 Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide
452.10 content expertise, technical expertise, ~~and~~ training to grant recipients and advice on
452.11 evidence-based strategies, including those based on populations and types of communities
452.12 served. The commissioner shall ensure that the statewide health improvement program
452.13 meets the outcomes established under subdivision 2 by conducting a comprehensive
452.14 statewide evaluation and assisting grant recipients to modify or discontinue interventions
452.15 found to be ineffective.

452.16 (b) For the purposes of carrying out the grant program under this section, including
452.17 for administrative purposes, the commissioner shall award contracts to appropriate entities
452.18 to assist in training and provide technical assistance to grantees.

452.19 (c) Contracts awarded under paragraph (b) may be used to provide technical
452.20 assistance and training in the areas of:

452.21 (1) community engagement and capacity building;

452.22 (2) tribal support;

452.23 (3) community asset building and risk behavior reduction;

452.24 (4) legal;

452.25 (5) communications;

452.26 (6) community, school, health care, work site, and other site-specific strategies; and

452.27 (7) health equity.

452.28 Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision
452.29 3, the commissioner shall conduct ~~a biennial~~ an evaluation of the statewide health
452.30 improvement program funded under this section. Grant recipients shall cooperate with
452.31 the commissioner in the evaluation and provide the commissioner with the information
452.32 necessary to conduct the evaluation.

452.33 (b) Grant recipients will collect, monitor, and submit to the Department of Health
452.34 baseline and annual data, and provide information to improve the quality and impact of
452.35 community health improvement strategies.

(c) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in designing and implementing evaluation systems.

(d) Contracts awarded under paragraph (c) may be used to:

(1) develop grantee monitoring and reporting systems to track grantee progress, including aggregated and disaggregated data;

(2) manage, analyze, and report program evaluation data results; and

(3) utilize innovative support tools to analyze and predict the impact of prevention strategies on health outcomes and state health care costs over time.

Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. ~~In the report due on January 15, 2010, the commissioner shall include recommendations on a sustainable funding source for the statewide health improvement program other than the health care access fund.~~

Subd. 6. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs that work to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco, or replace discontinued state or federal funds previously used to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco. Funds must not be used to supplant current state or local funding to community health boards or tribal governments used to reduce the percentage of Minnesotans who are obese or overweight or to reduce tobacco use.

Sec. 15. Minnesota Statutes 2012, section 149A.02, subdivision 1a, is amended to read:

Subd. 1a. **Alkaline hydrolysis.** "Alkaline hydrolysis" means the reduction of a dead human body to essential elements through ~~exposure to a combination of heat and alkaline hydrolysis and the repositioning or movement of the body during the process to facilitate reduction,~~ a water-based dissolution process using alkaline chemicals, heat, agitation, and pressure to accelerate natural decomposition; the processing of the hydrolyzed remains after removal from the alkaline hydrolysis ~~chamber,~~ vessel; placement of the processed remains in a hydrolyzed remains container~~,~~; and release of the hydrolyzed remains to an appropriate party. Alkaline hydrolysis is a form of final disposition.

454.1 Sec. 16. Minnesota Statutes 2012, section 149A.02, is amended by adding a
454.2 subdivision to read:
454.3 Subd. 1b. **Alkaline hydrolysis container.** "Alkaline hydrolysis container" means a
454.4 hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily
454.5 fluids that encases the body and into which a dead human body is placed prior to insertion
454.6 into an alkaline hydrolysis vessel. Alkaline hydrolysis containers may be hydrolyzable or
454.7 biodegradable alternative containers or caskets.

454.8 Sec. 17. Minnesota Statutes 2012, section 149A.02, is amended by adding a
454.9 subdivision to read:
454.10 Subd. 1c. **Alkaline hydrolysis facility.** "Alkaline hydrolysis facility" means a
454.11 building or structure containing one or more alkaline hydrolysis vessels for the alkaline
454.12 hydrolysis of dead human bodies.

454.13 Sec. 18. Minnesota Statutes 2012, section 149A.02, is amended by adding a
454.14 subdivision to read:
454.15 Subd. 1d. **Alkaline hydrolysis vessel.** "Alkaline hydrolysis vessel" means the
454.16 container in which the alkaline hydrolysis of a dead human body is performed.

454.17 Sec. 19. Minnesota Statutes 2012, section 149A.02, subdivision 2, is amended to read:
454.18 Subd. 2. **Alternative container.** "Alternative container" means a nonmetal
454.19 receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed
454.20 for the encasement of dead human bodies and is made of hydrolyzable or biodegradable
454.21 materials, corrugated cardboard, fiberboard, pressed-wood, or other like materials.

454.22 Sec. 20. Minnesota Statutes 2012, section 149A.02, subdivision 3, is amended to read:
454.23 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means
454.24 any action normally taken by a funeral provider in anticipation of or preparation for the
454.25 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

454.26 Sec. 21. Minnesota Statutes 2012, section 149A.02, is amended by adding a
454.27 subdivision to read:
454.28 Subd. 3c. **Branch funeral establishment.** "Branch funeral establishment" means
454.29 any place or premise used as the office or place of business that provides funeral goods
454.30 or services, except on-site preparation of the body, to the public. A branch funeral
454.31 establishment is subject to the licensing requirements of sections 149A.50 and 149A.51,

455.1 except section 149A.50, subdivision 2, clause (1). A branch funeral establishment must be
455.2 associated through a majority ownership of a licensed funeral establishment which meets
455.3 the requirements of sections 149A.50 and 149A.92, subdivisions 2 to 10.

455.4 Sec. 22. Minnesota Statutes 2012, section 149A.02, subdivision 4, is amended to read:
455.5 Subd. 4. **Cash advance item.** "Cash advance item" means any item of service
455.6 or merchandise described to a purchaser as a "cash advance," "accommodation," "cash
455.7 disbursement," or similar term. A cash advance item is also any item obtained from a
455.8 third party and paid for by the funeral provider on the purchaser's behalf. Cash advance
455.9 items include, but are not limited to, cemetery, alkaline hydrolysis, or crematory services,
455.10 pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, obituary
455.11 notices, gratuities, and death records.

455.12 Sec. 23. Minnesota Statutes 2012, section 149A.02, subdivision 5, is amended to read:
455.13 Subd. 5. **Casket.** "Casket" means a rigid container which is designed for the
455.14 encasement of a dead human body and is usually constructed of hydrolyzable or
455.15 biodegradable materials, wood, metal, fiberglass, plastic, or like material, and ornamented
455.16 and lined with fabric.

455.17 Sec. 24. Minnesota Statutes 2012, section 149A.02, is amended by adding a
455.18 subdivision to read:
455.19 Subd. 12a. **Crypt.** "Crypt" means a space in a mausoleum of sufficient size, used or
455.20 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.

455.21 Sec. 25. Minnesota Statutes 2012, section 149A.02, is amended by adding a
455.22 subdivision to read:
455.23 Subd. 12b. **Direct alkaline hydrolysis.** "Direct alkaline hydrolysis" means a
455.24 final disposition of a dead human body by alkaline hydrolysis, without formal viewing,
455.25 visitation, or ceremony with the body present.

455.26 Sec. 26. Minnesota Statutes 2012, section 149A.02, subdivision 16, is amended to read:
455.27 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the
455.28 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

455.29 Sec. 27. Minnesota Statutes 2012, section 149A.02, subdivision 23, is amended to read:

456.1 Subd. 23. **Funeral services.** "Funeral services" means any services which may
456.2 be used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis,
456.3 cremation, or other final disposition; and (2) arrange, supervise, or conduct the funeral
456.4 ceremony or the final disposition of dead human bodies.

456.5 Sec. 28. Minnesota Statutes 2012, section 149A.02, is amended by adding a
456.6 subdivision to read:
456.7 Subd. 24a. **Holding facility.** "Holding facility" means a secure enclosed room or
456.8 confined area within a funeral establishment, branch funeral establishment, crematory,
456.9 or alkaline hydrolysis facility used for temporary storage of human remains awaiting
456.10 final disposition.

456.11 Sec. 29. Minnesota Statutes 2012, section 149A.02, is amended by adding a
456.12 subdivision to read:
456.13 Subd. 24b. **Hydrolyzed remains.** "Hydrolyzed remains" means the remains of a
456.14 dead human body following the alkaline hydrolysis process. Hydrolyzed remains does not
456.15 include pacemakers, prostheses, or similar foreign materials.

456.16 Sec. 30. Minnesota Statutes 2012, section 149A.02, is amended by adding a
456.17 subdivision to read:
456.18 Subd. 24c. **Hydrolyzed remains container.** "Hydrolyzed remains container" means
456.19 a receptacle in which hydrolyzed remains are placed. For purposes of this chapter, a
456.20 hydrolyzed remains container is interchangeable with "urn" or similar keepsake storage
456.21 jewelry.

456.22 Sec. 31. Minnesota Statutes 2012, section 149A.02, is amended by adding a
456.23 subdivision to read:
456.24 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains
456.25 in a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.

456.26 Sec. 32. Minnesota Statutes 2012, section 149A.02, subdivision 27, is amended to read:
456.27 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued
456.28 a license to practice mortuary science, to operate a funeral establishment, to operate an
456.29 alkaline hydrolysis facility, or to operate a crematory by the Minnesota commissioner
456.30 of health.

457.1 Sec. 33. Minnesota Statutes 2012, section 149A.02, is amended by adding a
457.2 subdivision to read:
457.3 Subd. 30a. **Niche.** "Niche" means a space in a columbarium used, or intended to be
457.4 used, for the placement of hydrolyzed or cremated remains.

457.5 Sec. 34. Minnesota Statutes 2012, section 149A.02, is amended by adding a
457.6 subdivision to read:
457.7 Subd. 32a. **Placement.** "Placement" means the placing of a container holding
457.8 hydrolyzed or cremated remains in a crypt, vault, or niche.

457.9 Sec. 35. Minnesota Statutes 2012, section 149A.02, subdivision 34, is amended to read:
457.10 Subd. 34. **Preparation of the body.** "Preparation of the body" means placement of
457.11 the body into an appropriate cremation or alkaline hydrolysis container, embalming of
457.12 the body or such items of care as washing, disinfecting, shaving, positioning of features,
457.13 restorative procedures, application of cosmetics, dressing, and casketing.

457.14 Sec. 36. Minnesota Statutes 2012, section 149A.02, subdivision 35, is amended to read:
457.15 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or
457.16 cooling, and the reduction of the hydrolyzed or cremated remains by mechanical means
457.17 including, but not limited to, grinding, crushing, or pulverizing, to a granulated appearance
457.18 appropriate for final disposition.

457.19 Sec. 37. Minnesota Statutes 2012, section 149A.02, subdivision 37, is amended to read:
457.20 Subd. 37. **Public transportation.** "Public transportation" means all manner of
457.21 transportation via common carrier available to the general public including airlines, buses,
457.22 railroads, and ships. For purposes of this chapter, a livery service providing transportation
457.23 to private funeral establishments, alkaline hydrolysis facilities, or crematories is not public
457.24 transportation.

457.25 Sec. 38. Minnesota Statutes 2012, section 149A.02, is amended by adding a
457.26 subdivision to read:
457.27 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed
457.28 or cremated remains in a defined area of a dedicated cemetery or in areas where no local
457.29 prohibition exists provided that the hydrolyzed or cremated remains are not distinguishable
457.30 to the public, are not in a container, and that the person who has control over disposition

458.1 of the hydrolyzed or cremated remains has obtained written permission of the property
458.2 owner or governing agency to scatter on the property.

458.3 Sec. 39. Minnesota Statutes 2012, section 149A.02, is amended by adding a
458.4 subdivision to read:

458.5 Subd. 41. **Vault.** "Vault" means a space in a mausoleum of sufficient size, used or
458.6 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.
458.7 Vault may also mean a sealed and lined casket enclosure.

458.8 Sec. 40. Minnesota Statutes 2012, section 149A.03, is amended to read:

458.9 **149A.03 DUTIES OF COMMISSIONER.**

458.10 The commissioner shall:

458.11 (1) enforce all laws and adopt and enforce rules relating to the:

458.12 (i) removal, preparation, transportation, arrangements for disposition, and final
458.13 disposition of dead human bodies;

458.14 (ii) licensure and professional conduct of funeral directors, morticians, interns,
458.15 practicum students, and clinical students;

458.16 (iii) licensing and operation of a funeral establishment; ~~and~~

458.17 (iv) licensing and operation of an alkaline hydrolysis facility; and

458.18 ~~(iv)~~ (v) licensing and operation of a crematory;

458.19 (2) provide copies of the requirements for licensure and permits to all applicants;

458.20 (3) administer examinations and issue licenses and permits to qualified persons
458.21 and other legal entities;

458.22 (4) maintain a record of the name and location of all current licensees and interns;

458.23 (5) perform periodic compliance reviews and premise inspections of licensees;

458.24 (6) accept and investigate complaints relating to conduct governed by this chapter;

458.25 (7) maintain a record of all current preneed arrangement trust accounts;

458.26 (8) maintain a schedule of application, examination, permit, and licensure fees,
458.27 initial and renewal, sufficient to cover all necessary operating expenses;

458.28 (9) educate the public about the existence and content of the laws and rules for
458.29 mortuary science licensing and the removal, preparation, transportation, arrangements
458.30 for disposition, and final disposition of dead human bodies to enable consumers to file
458.31 complaints against licensees and others who may have violated those laws or rules;

458.32 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary
458.33 science in order to refine the standards for licensing and to improve the regulatory and
458.34 enforcement methods used; and

459.1 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in
459.2 the laws, rules, or procedures governing the practice of mortuary science and the removal,
459.3 preparation, transportation, arrangements for disposition, and final disposition of dead
459.4 human bodies.

459.5 Sec. 41. **[149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS**
459.6 **FACILITY.**

459.7 Subdivision 1. **License requirement.** Except as provided in section 149A.01,
459.8 subdivision 3, a place or premise shall not be maintained, managed, or operated which
459.9 is devoted to or used in the holding and alkaline hydrolysis of a dead human body
459.10 without possessing a valid license to operate an alkaline hydrolysis facility issued by the
459.11 commissioner of health.

459.12 Subd. 2. **Requirements for an alkaline hydrolysis facility.** (a) An alkaline
459.13 hydrolysis facility licensed under this section must consist of:

459.14 (1) a building or structure that complies with applicable local and state building
459.15 codes, zoning laws and ordinances, wastewater management and environmental standards,
459.16 containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead
459.17 human bodies;

459.18 (2) a method approved by the commissioner of health to dry the hydrolyzed remains
459.19 and which is located within the licensed facility;

459.20 (3) a means approved by the commissioner of health for refrigeration of dead human
459.21 bodies awaiting alkaline hydrolysis;

459.22 (4) an appropriate means of processing hydrolyzed remains to a granulated
459.23 appearance appropriate for final disposition; and

459.24 (5) an appropriate holding facility for dead human bodies awaiting alkaline
459.25 hydrolysis.

459.26 (b) An alkaline hydrolysis facility licensed under this section may also contain a
459.27 display room for funeral goods.

459.28 Subd. 3. **Application procedure; documentation; initial inspection.** An
459.29 application to license and operate an alkaline hydrolysis facility shall be submitted to the
459.30 commissioner of health. A completed application includes:

459.31 (1) a completed application form, as provided by the commissioner;

459.32 (2) proof of business form and ownership;

459.33 (3) proof of liability insurance coverage or other financial documentation, as
459.34 determined by the commissioner, that demonstrates the applicant's ability to respond in

460.1 damages for liability arising from the ownership, maintenance management, or operation
460.2 of an alkaline hydrolysis facility; and
460.3 (4) copies of wastewater and other environmental regulatory permits and
460.4 environmental regulatory licenses necessary to conduct operations.

460.5 Upon receipt of the application and appropriate fee, the commissioner shall review and
460.6 verify all information. Upon completion of the verification process and resolution of any
460.7 deficiencies in the application information, the commissioner shall conduct an initial
460.8 inspection of the premises to be licensed. After the inspection and resolution of any
460.9 deficiencies found and any reinspections as may be necessary, the commissioner shall
460.10 make a determination, based on all the information available, to grant or deny licensure. If
460.11 the commissioner's determination is to grant the license, the applicant shall be notified and
460.12 the license shall issue and remain valid for a period prescribed on the license, but not to
460.13 exceed one calendar year from the date of issuance of the license. If the commissioner's
460.14 determination is to deny the license, the commissioner must notify the applicant in writing
460.15 of the denial and provide the specific reason for denial.
460.16 Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis
460.17 facility is not assignable or transferable and shall not be valid for any entity other than the
460.18 one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the
460.19 location identified on the license. A 50 percent or more change in ownership or location of
460.20 the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall
460.21 be required of two or more persons or other legal entities operating from the same location.
460.22 Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis
460.23 facility must be conspicuously displayed in the alkaline hydrolysis facility at all times.
460.24 Conspicuous display means in a location where a member of the general public within the
460.25 alkaline hydrolysis facility will be able to observe and read the license.
460.26 Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility
460.27 issued by the commissioner are valid for a period of one calendar year beginning on July 1
460.28 and ending on June 30, regardless of the date of issuance.
460.29 Subd. 7. **Reporting changes in license information.** Any change of license
460.30 information must be reported to the commissioner, on forms provided by the
460.31 commissioner, no later than 30 calendar days after the change occurs. Failure to report
460.32 changes is grounds for disciplinary action.
460.33 Subd. 8. **Notification to the commissioner.** If the licensee is operating under a
460.34 wastewater or an environmental permit or license that is subsequently revoked, denied,
460.35 or terminated, the licensee shall notify the commissioner.

461.1 Subd. 9. **Application information.** All information submitted to the commissioner
461.2 for a license to operate an alkaline hydrolysis facility is classified as licensing data under
461.3 section 13.41, subdivision 5.

461.4 Sec. 42. **[149A.55] RENEWAL OF LICENSE TO OPERATE AN ALKALINE**
461.5 **HYDROLYSIS FACILITY.**

461.6 Subdivision 1. **Renewal required.** All licenses to operate an alkaline hydrolysis
461.7 facility issued by the commissioner expire on June 30 following the date of issuance of the
461.8 license and must be renewed to remain valid.

461.9 Subd. 2. **Renewal procedure and documentation.** Licensees who wish to renew
461.10 their licenses must submit to the commissioner a completed renewal application no later
461.11 than June 30 following the date the license was issued. A completed renewal application
461.12 includes:

461.13 (1) a completed renewal application form, as provided by the commissioner; and

461.14 (2) proof of liability insurance coverage or other financial documentation, as
461.15 determined by the commissioner, that demonstrates the applicant's ability to respond in
461.16 damages for liability arising from the ownership, maintenance, management, or operation
461.17 of an alkaline hydrolysis facility.

461.18 Upon receipt of the completed renewal application, the commissioner shall review and
461.19 verify the information. Upon completion of the verification process and resolution of
461.20 any deficiencies in the renewal application information, the commissioner shall make a
461.21 determination, based on all the information available, to reissue or refuse to reissue the
461.22 license. If the commissioner's determination is to reissue the license, the applicant shall
461.23 be notified and the license shall issue and remain valid for a period prescribed on the
461.24 license, but not to exceed one calendar year from the date of issuance of the license. If
461.25 the commissioner's determination is to refuse to reissue the license, section 149A.09,
461.26 subdivision 2, applies.

461.27 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration
461.28 date of a license will result in the assessment of a late filing penalty. The late filing penalty
461.29 must be paid before the reissuance of the license and received by the commissioner no
461.30 later than 31 calendar days after the expiration date of the license.

461.31 Subd. 4. **Lapse of license.** Licenses to operate alkaline hydrolysis facilities
461.32 shall automatically lapse when a completed renewal application is not received by the
461.33 commissioner within 31 calendar days after the expiration date of a license, or a late
461.34 filing penalty assessed under subdivision 3 is not received by the commissioner within 31
461.35 calendar days after the expiration of a license.

462.1 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom
462.2 the license was issued is no longer licensed to operate an alkaline hydrolysis facility in
462.3 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed
462.4 license holder from operating an alkaline hydrolysis facility in Minnesota and may pursue
462.5 any additional lawful remedies as justified by the case.

462.6 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed
462.7 license upon receipt and review of a completed renewal application, receipt of the late
462.8 filing penalty, and reinspection of the premises, provided that the receipt is made within
462.9 one calendar year from the expiration date of the lapsed license and the cease and desist
462.10 order issued by the commissioner has not been violated. If a lapsed license is not restored
462.11 within one calendar year from the expiration date of the lapsed license, the holder of the
462.12 lapsed license cannot be relicensed until the requirements in section 149A.54 are met.

462.13 Subd. 7. **Reporting changes in license information.** Any change of license
462.14 information must be reported to the commissioner, on forms provided by the
462.15 commissioner, no later than 30 calendar days after the change occurs. Failure to report
462.16 changes is grounds for disciplinary action.

462.17 Subd. 8. **Application information.** All information submitted to the commissioner
462.18 by an applicant for renewal of licensure to operate an alkaline hydrolysis facility is
462.19 classified as licensing data under section 13.41, subdivision 5.

462.20 Sec. 43. Minnesota Statutes 2012, section 149A.65, is amended by adding a
462.21 subdivision to read:

462.22 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline
462.23 hydrolysis facility is $300. The late fee charge for a license renewal is $25.

462.24 Sec. 44. Minnesota Statutes 2012, section 149A.65, is amended by adding a
462.25 subdivision to read:

462.26 Subd. 7. **State government special revenue fund.** Fees collected by the
462.27 commissioner under this section must be deposited in the state treasury and credited to
462.28 the state government special revenue fund.

462.29 Sec. 45. Minnesota Statutes 2012, section 149A.70, subdivision 1, is amended to read:

462.30 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice
462.31 mortuary science issued by the commissioner may use the title of mortician, funeral
462.32 director, or any other title implying that the licensee is engaged in the business or practice
462.33 of mortuary science. Only the holder of a valid license to operate an alkaline hydrolysis

463.1 facility issued by the commissioner may use the title of alkaline hydrolysis facility, water
463.2 cremation, water-reduction, biocremation, green-cremation, resomation, dissolution, or
463.3 any other title, word, or term implying that the licensee operates an alkaline hydrolysis
463.4 facility. Only the holder of a valid license to operate a funeral establishment issued by the
463.5 commissioner may use the title of funeral home, funeral chapel, funeral service, or any
463.6 other title, word, or term implying that the licensee is engaged in the business or practice
463.7 of mortuary science. Only the holder of a valid license to operate a crematory issued by
463.8 the commissioner may use the title of crematory, crematorium, green-cremation, or any
463.9 other title, word, or term implying that the licensee operates a crematory or crematorium.

463.10 Sec. 46. Minnesota Statutes 2012, section 149A.70, subdivision 2, is amended to read:
463.11 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, or
463.12 crematory shall not do business in a location that is not licensed as a funeral establishment,
463.13 alkaline hydrolysis facility, or crematory and shall not advertise a service that is available
463.14 from an unlicensed location.

463.15 Sec. 47. Minnesota Statutes 2012, section 149A.70, subdivision 3, is amended to read:
463.16 Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern
463.17 shall publish or disseminate false, misleading, or deceptive advertising. False, misleading,
463.18 or deceptive advertising includes, but is not limited to:
463.19 (1) identifying, by using the names or pictures of, persons who are not licensed to
463.20 practice mortuary science in a way that leads the public to believe that those persons will
463.21 provide mortuary science services;
463.22 (2) using any name other than the names under which the funeral establishment,
463.23 alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;
463.24 (3) using a surname not directly, actively, or presently associated with a licensed
463.25 funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had
463.26 been previously and continuously used by the licensed funeral establishment, alkaline
463.27 hydrolysis facility, or crematory; and
463.28 (4) using a founding or establishing date or total years of service not directly or
463.29 continuously related to a name under which the funeral establishment, alkaline hydrolysis
463.30 facility, or crematory is currently or was previously licensed.
463.31 Any advertising or other printed material that contains the names or pictures of
463.32 persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory
463.33 shall state the position held by the persons and shall identify each person who is licensed
463.34 or unlicensed under this chapter.

Sec. 48. Minnesota Statutes 2012, section 149A.70, subdivision 5, is amended to read:

Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student, or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other reimbursement in consideration for recommending or causing a dead human body to be disposed of by a specific body donation program, funeral establishment, alkaline hydrolysis facility, crematory, mausoleum, or cemetery.

Sec. 49. Minnesota Statutes 2012, section 149A.71, subdivision 2, is amended to read:

Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or practices, the requirements of this subdivision must be met.

(b) Funeral providers must tell persons who ask by telephone about the funeral provider's offerings or prices any accurate information from the price lists described in paragraphs (c) to (e) and any other readily available information that reasonably answers the questions asked.

(c) Funeral providers must make available for viewing to people who inquire in person about the offerings or prices of funeral goods or burial site goods, separate printed or typewritten price lists using a ten-point font or larger. Each funeral provider must have a separate price list for each of the following types of goods that are sold or offered for sale:

(1) caskets;

(2) alternative containers;

(3) outer burial containers;

(4) alkaline hydrolysis containers;

~~(4)~~ (5) cremation containers;

(6) hydrolyzed remains containers;

~~(5)~~ (7) cremated remains containers;

~~(6)~~ (8) markers; and

~~(7)~~ (9) headstones.

(d) Each separate price list must contain the name of the funeral provider's place of business, address, and telephone number and a caption describing the list as a price list for one of the types of funeral goods or burial site goods described in paragraph (c), clauses (1) to ~~(7)~~ (9). The funeral provider must offer the list upon beginning discussion of, but in any event before showing, the specific funeral goods or burial site goods and must provide a photocopy of the price list, for retention, if so asked by the consumer. The list must contain, at least, the retail prices of all the specific funeral goods and burial site goods offered which do not require special ordering, enough information to identify each, and the effective date for the price list. However, funeral providers are not required to

465.1 make a specific price list available if the funeral providers place the information required
465.2 by this paragraph on the general price list described in paragraph (e).

465.3 (e) Funeral providers must give a printed price list, for retention, to persons who
465.4 inquire in person about the funeral goods, funeral services, burial site goods, or burial site
465.5 services or prices offered by the funeral provider. The funeral provider must give the list
465.6 upon beginning discussion of either the prices of or the overall type of funeral service or
465.7 disposition or specific funeral goods, funeral services, burial site goods, or burial site
465.8 services offered by the provider. This requirement applies whether the discussion takes
465.9 place in the funeral establishment or elsewhere. However, when the deceased is removed
465.10 for transportation to the funeral establishment, an in-person request for authorization to
465.11 embalm does not, by itself, trigger the requirement to offer the general price list. If the
465.12 provider, in making an in-person request for authorization to embalm, discloses that
465.13 embalming is not required by law except in certain special cases, the provider is not
465.14 required to offer the general price list. Any other discussion during that time about prices
465.15 or the selection of funeral goods, funeral services, burial site goods, or burial site services
465.16 triggers the requirement to give the consumer a general price list. The general price list
465.17 must contain the following information:

465.18 (1) the name, address, and telephone number of the funeral provider's place of
465.19 business;

465.20 (2) a caption describing the list as a "general price list";

465.21 (3) the effective date for the price list;

465.22 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per
465.23 hour, mile, or other unit of computation, and other information described as follows:

465.24 (i) forwarding of remains to another funeral establishment, together with a list of
465.25 the services provided for any quoted price;

465.26 (ii) receiving remains from another funeral establishment, together with a list of
465.27 the services provided for any quoted price;

465.28 (iii) separate prices for each alkaline hydrolysis or cremation offered by the funeral
465.29 provider, with the price including an alternative container or alkaline hydrolysis or
465.30 cremation container, any alkaline hydrolysis or crematory charges, and a description of the
465.31 services and container included in the price, where applicable, and the price of alkaline
465.32 hydrolysis or cremation where the purchaser provides the container;

465.33 (iv) separate prices for each immediate burial offered by the funeral provider,
465.34 including a casket or alternative container, and a description of the services and container
465.35 included in that price, and the price of immediate burial where the purchaser provides the
465.36 casket or alternative container;

466.1 (v) transfer of remains to the funeral establishment or other location;
466.2 (vi) embalming;
466.3 (vii) other preparation of the body;
466.4 (viii) use of facilities, equipment, or staff for viewing;
466.5 (ix) use of facilities, equipment, or staff for funeral ceremony;
466.6 (x) use of facilities, equipment, or staff for memorial service;
466.7 (xi) use of equipment or staff for graveside service;
466.8 (xii) hearse or funeral coach;
466.9 (xiii) limousine; and
466.10 (xiv) separate prices for all cemetery-specific goods and services, including all goods
466.11 and services associated with interment and burial site goods and services and excluding
466.12 markers and headstones;
466.13 (5) the price range for the caskets offered by the funeral provider, together with the
466.14 statement "A complete price list will be provided at the funeral establishment or casket
466.15 sale location." or the prices of individual caskets, as disclosed in the manner described
466.16 in paragraphs (c) and (d);
466.17 (6) the price range for the alternative containers offered by the funeral provider,
466.18 together with the statement "A complete price list will be provided at the funeral
466.19 establishment or alternative container sale location." or the prices of individual alternative
466.20 containers, as disclosed in the manner described in paragraphs (c) and (d);
466.21 (7) the price range for the outer burial containers offered by the funeral provider,
466.22 together with the statement "A complete price list will be provided at the funeral
466.23 establishment or outer burial container sale location." or the prices of individual outer
466.24 burial containers, as disclosed in the manner described in paragraphs (c) and (d);
466.25 (8) the price range for the alkaline hydrolysis container offered by the funeral
466.26 provider, together with the statement: "A complete price list will be provided at the funeral
466.27 establishment or alkaline hydrolysis container sale location.", or the prices of individual
466.28 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c)
466.29 and (d);
466.30 (9) the price range for the hydrolyzed remains container offered by the funeral
466.31 provider, together with the statement: "A complete price list will be provided at the
466.32 funeral establishment or hydrolyzed remains container sale location.", or the prices
466.33 of individual hydrolyzed remains container, as disclosed in the manner described in
466.34 paragraphs (c) and (d);
466.35 ~~(8)~~ (10) the price range for the cremation containers offered by the funeral provider,
466.36 together with the statement "A complete price list will be provided at the funeral

467.1 establishment or cremation container sale location." or the prices of individual cremation
467.2 containers~~ and cremated remains containers~~, as disclosed in the manner described in
467.3 paragraphs (c) and (d);
467.4 ~~(9)~~ (11) the price range for the cremated remains containers offered by the funeral
467.5 provider, together with the statement, "A complete price list will be provided at the funeral
467.6 establishment or ~~cremation~~ cremated remains container sale location," or the prices of
467.7 individual cremation containers as disclosed in the manner described in paragraphs (c)
467.8 and (d);
467.9 ~~(10)~~ (12) the price for the basic services of funeral provider and staff, together with a
467.10 list of the principal basic services provided for any quoted price and, if the charge cannot
467.11 be declined by the purchaser, the statement "This fee for our basic services will be added
467.12 to the total cost of the funeral arrangements you select. (This fee is already included in
467.13 our charges for alkaline hydrolysis, direct cremations, immediate burials, and forwarding
467.14 or receiving remains.)" If the charge cannot be declined by the purchaser, the quoted
467.15 price shall include all charges for the recovery of unallocated funeral provider overhead,
467.16 and funeral providers may include in the required disclosure the phrase "and overhead"
467.17 after the word "services." This services fee is the only funeral provider fee for services,
467.18 facilities, or unallocated overhead permitted by this subdivision to be nondeclinable,
467.19 unless otherwise required by law;
467.20 ~~(11)~~ (13) the price range for the markers and headstones offered by the funeral
467.21 provider, together with the statement "A complete price list will be provided at the funeral
467.22 establishment or marker or headstone sale location." or the prices of individual markers
467.23 and headstones, as disclosed in the manner described in paragraphs (c) and (d); and
467.24 ~~(12)~~ (14) any package priced funerals offered must be listed in addition to and
467.25 following the information required in paragraph (e) and must clearly state the funeral
467.26 goods and services being offered, the price being charged for those goods and services,
467.27 and the discounted savings.
467.28 (f) Funeral providers must give an itemized written statement, for retention, to each
467.29 consumer who arranges an at-need funeral or other disposition of human remains at the
467.30 conclusion of the discussion of the arrangements. The itemized written statement must be
467.31 signed by the consumer selecting the goods and services as required in section 149A.80.
467.32 If the statement is provided by a funeral establishment, the statement must be signed by
467.33 the licensed funeral director or mortician planning the arrangements. If the statement is
467.34 provided by any other funeral provider, the statement must be signed by an authorized
467.35 agent of the funeral provider. The statement must list the funeral goods, funeral services,
467.36 burial site goods, or burial site services selected by that consumer and the prices to be paid

468.1 for each item, specifically itemized cash advance items (these prices must be given to the
468.2 extent then known or reasonably ascertainable if the prices are not known or reasonably
468.3 ascertainable, a good faith estimate shall be given and a written statement of the actual
468.4 charges shall be provided before the final bill is paid), and the total cost of goods and
468.5 services selected. At the conclusion of an at-need arrangement, the funeral provider is
468.6 required to give the consumer a copy of the signed itemized written contract that must
468.7 contain the information required in this paragraph.

468.8 (g) Upon receiving actual notice of the death of an individual with whom a funeral
468.9 provider has entered a preneed funeral agreement, the funeral provider must provide
468.10 a copy of all preneed funeral agreement documents to the person who controls final
468.11 disposition of the human remains or to the designee of the person controlling disposition.
468.12 The person controlling final disposition shall be provided with these documents at the time
468.13 of the person's first in-person contact with the funeral provider, if the first contact occurs
468.14 in person at a funeral establishment, alkaline hydrolysis facility, crematory, or other place
468.15 of business of the funeral provider. If the contact occurs by other means or at another
468.16 location, the documents must be provided within 24 hours of the first contact.

468.17 Sec. 50. Minnesota Statutes 2012, section 149A.71, subdivision 4, is amended to read:

468.18 Subd. 4. **Casket, alternate container, alkaline hydrolysis containers, and**
468.19 **cremation container sales; records; required disclosures.** Any funeral provider who
468.20 sells or offers to sell a casket, alternate container, alkaline hydrolysis container, hydrolyzed
468.21 remains container, or cremation container, or cremated remains container to the public
468.22 must maintain a record of each sale that includes the name of the purchaser, the purchaser's
468.23 mailing address, the name of the decedent, the date of the decedent's death, and the place
468.24 of death. These records shall be open to inspection by the regulatory agency. Any funeral
468.25 provider selling a casket, alternate container, or cremation container to the public, and not
468.26 having charge of the final disposition of the dead human body, shall provide a copy of the
468.27 statutes and rules controlling the removal, preparation, transportation, arrangements for
468.28 disposition, and final disposition of a dead human body. This subdivision does not apply to
468.29 morticians, funeral directors, funeral establishments, crematories, or wholesale distributors
468.30 of caskets, alternate containers, alkaline hydrolysis containers, or cremation containers.

468.31 Sec. 51. Minnesota Statutes 2012, section 149A.72, subdivision 3, is amended to read:

468.32 Subd. 3. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts**
468.33 **or practices.** In selling or offering to sell funeral goods or funeral services to the public, it

469.1 is a deceptive act or practice for a funeral provider to represent that a casket is required for
469.2 alkaline hydrolysis or cremations by state or local law or otherwise.

469.3 Sec. 52. Minnesota Statutes 2012, section 149A.72, is amended by adding a
469.4 subdivision to read:

469.5 Subd. 3a. **Casket for alkaline hydrolysis provision; preventive measures.** To
469.6 prevent deceptive acts or practices, funeral providers must place the following disclosure
469.7 in immediate conjunction with the prices shown for alkaline hydrolysis: "Minnesota
469.8 law does not require you to purchase a casket for alkaline hydrolysis. If you want to
469.9 arrange for alkaline hydrolysis, you can use an alkaline hydrolysis container. An alkaline
469.10 hydrolysis container is a hydrolyzable or biodegradable closed container or pouch resistant
469.11 to leakage of bodily fluids that encases the body and into which a dead human body is
469.12 placed prior to insertion into an alkaline hydrolysis vessel. The containers we provide
469.13 are (specify containers provided)." This disclosure is required only if the funeral provider
469.14 arranges alkaline hydrolysis.

469.15 Sec. 53. Minnesota Statutes 2012, section 149A.72, subdivision 9, is amended to read:

469.16 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods,
469.17 funeral services, burial site goods, or burial site services to the public, it is a deceptive act
469.18 or practice for a funeral provider to represent that federal, state, or local laws, or particular
469.19 cemeteries, alkaline hydrolysis facilities, or crematories, require the purchase of any funeral
469.20 goods, funeral services, burial site goods, or burial site services when that is not the case.

469.21 Sec. 54. Minnesota Statutes 2012, section 149A.73, subdivision 1, is amended to read:

469.22 Subdivision 1. **Casket for alkaline hydrolysis or cremation provisions; deceptive**
469.23 **acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site
469.24 goods, or burial site services to the public, it is a deceptive act or practice for a funeral
469.25 provider to require that a casket be purchased for alkaline hydrolysis or cremation.

469.26 Sec. 55. Minnesota Statutes 2012, section 149A.73, subdivision 2, is amended to read:

469.27 Subd. 2. **Casket for alkaline hydrolysis or cremation; preventive requirements.**
469.28 To prevent unfair or deceptive acts or practices, if funeral providers arrange for alkaline
469.29 hydrolysis or cremations, they must make ~~a~~ an alkaline hydrolysis container or cremation
469.30 container available for alkaline hydrolysis or cremations.

469.31 Sec. 56. Minnesota Statutes 2012, section 149A.73, subdivision 4, is amended to read:

470.1 Subd. 4. **Required purchases of funeral goods or services; preventive**
470.2 **requirements.** To prevent unfair or deceptive acts or practices, funeral providers must
470.3 place the following disclosure in the general price list, immediately above the prices
470.4 required by section 149A.71, subdivision 2, paragraph (e), clauses (4) to (10): "The goods
470.5 and services shown below are those we can provide to our customers. You may choose
470.6 only the items you desire. If legal or other requirements mean that you must buy any items
470.7 you did not specifically ask for, we will explain the reason in writing on the statement we
470.8 provide describing the funeral goods, funeral services, burial site goods, and burial site
470.9 services you selected." However, if the charge for "services of funeral director and staff"
470.10 cannot be declined by the purchaser, the statement shall include the sentence "However,
470.11 any funeral arrangements you select will include a charge for our basic services." between
470.12 the second and third sentences of the sentences specified in this subdivision. The statement
470.13 may include the phrase "and overhead" after the word "services" if the fee includes a
470.14 charge for the recovery of unallocated funeral overhead. If the funeral provider does
470.15 not include this disclosure statement, then the following disclosure statement must be
470.16 placed in the statement of funeral goods, funeral services, burial site goods, and burial site
470.17 services selected, as described in section 149A.71, subdivision 2, paragraph (f): "Charges
470.18 are only for those items that you selected or that are required. If we are required by law or
470.19 by a cemetery, alkaline hydrolysis facility, or crematory to use any items, we will explain
470.20 the reasons in writing below." A funeral provider is not in violation of this subdivision by
470.21 failing to comply with a request for a combination of goods or services which would be
470.22 impossible, impractical, or excessively burdensome to provide.

470.23 Sec. 57. Minnesota Statutes 2012, section 149A.74, is amended to read:

470.24 **149A.74 FUNERAL SERVICES PROVIDED WITHOUT PRIOR APPROVAL.**

470.25 Subdivision 1. **Services provided without prior approval; deceptive acts or**
470.26 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it
470.27 is a deceptive act or practice for any funeral provider to embalm a dead human body
470.28 unless state or local law or regulation requires embalming in the particular circumstances
470.29 regardless of any funeral choice which might be made, or prior approval for embalming
470.30 has been obtained from an individual legally authorized to make such a decision. In
470.31 seeking approval to embalm, the funeral provider must disclose that embalming is not
470.32 required by law except in certain circumstances; that a fee will be charged if a funeral
470.33 is selected which requires embalming, such as a funeral with viewing; and that no
470.34 embalming fee will be charged if the family selects a service which does not require
470.35 embalming, such as direct alkaline hydrolysis, direct cremation, or immediate burial.

471.1 Subd. 2. **Services provided without prior approval; preventive requirement.**
471.2 To prevent unfair or deceptive acts or practices, funeral providers must include on
471.3 the itemized statement of funeral goods or services, as described in section 149A.71,
471.4 subdivision 2, paragraph (f), the statement "If you selected a funeral that may require
471.5 embalming, such as a funeral with viewing, you may have to pay for embalming. You do
471.6 not have to pay for embalming you did not approve if you selected arrangements such
471.7 as direct alkaline hydrolysis, direct cremation, or immediate burial. If we charged for
471.8 embalming, we will explain why below."

471.9 Sec. 58. Minnesota Statutes 2012, section 149A.90, subdivision 8, is amended to read:
471.10 Subd. 8. **Proper holding facility required.** The funeral establishment to which a
471.11 dead human body is taken shall have an appropriate holding facility for storing the body
471.12 while awaiting final disposition. The holding facility must be secure from access by
471.13 anyone except the authorized personnel of the funeral establishment, preserve the dignity
471.14 of the remains, and protect the health and safety of the funeral establishment personnel. A
471.15 holding facility may not be used for preparation or embalming of the body.

471.16 Sec. 59. Minnesota Statutes 2012, section 149A.91, subdivision 9, is amended to read:
471.17 Subd. 9. **~~Embalmed~~ Bodies awaiting final disposition.** All ~~embalmed~~ bodies
471.18 awaiting final disposition shall be kept in an appropriate holding facility or preparation
471.19 and embalming room. The holding facility must be secure from access by anyone except
471.20 the authorized personnel of the funeral establishment, preserve the dignity and integrity of
471.21 the body, and protect the health and safety of the personnel of the funeral establishment.

471.22 Sec. 60. Minnesota Statutes 2012, section 149A.92, subdivision 1, is amended to read:
471.23 Subdivision 1. **~~Exemption~~ Exemptions.** (a) All funeral establishments having a
471.24 preparation and embalming room that has not been used for the preparation or embalming
471.25 of a dead human body in the 12 calendar months prior to July 1, 1997, are exempt from
471.26 the minimum requirements in subdivisions 2 to 6, except as provided in this section. At
471.27 the time that ownership of a funeral establishment changes, the physical location of the
471.28 establishment changes, or the building housing the funeral establishment or business space
471.29 of the establishment is remodeled the existing preparation and embalming room must be
471.30 brought into compliance with the minimum standards in this section.
471.31 (b) Funeral establishments are not required to contain a preparation and embalming
471.32 room when it is a branch funeral establishment of a Minnesota licensed funeral

472.1 establishment that has a preparation and embalming room meeting the standards set forth
472.2 in subdivisions 2 to 10.

472.3 Sec. 61. Minnesota Statutes 2012, section 149A.93, subdivision 3, is amended to read:
472.4 Subd. 3. **Disposition permit.** A disposition permit is required before a body can
472.5 be buried, entombed, alkaline hydrolyzed, or cremated. No disposition permit shall be
472.6 issued until a fact of death record has been completed and filed with the local or state
472.7 registrar of vital statistics.

472.8 Sec. 62. Minnesota Statutes 2012, section 149A.93, subdivision 6, is amended to read:
472.9 Subd. 6. **Conveyances permitted for transportation.** A dead human body may be
472.10 transported by means of private vehicle or private aircraft, provided that the body must be
472.11 encased in an appropriate container, that meets the following standards:
472.12 (1) promotes respect for and preserves the dignity of the dead human body;
472.13 (2) shields the body from being viewed from outside of the conveyance;
472.14 (3) has ample enclosed area to accommodate a cot, stretcher, rigid tray, casket,
472.15 alternative container, alkaline hydrolysis container, or cremation container in a horizontal
472.16 position;
472.17 (4) is designed to permit loading and unloading of the body without excessive tilting
472.18 of the cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container,
472.19 or cremation container; and
472.20 (5) if used for the transportation of more than one dead human body at one time,
472.21 the vehicle must be designed so that a body or container does not rest directly on top of
472.22 another body or container and that each body or container is secured to prevent the body
472.23 or container from excessive movement within the conveyance.
472.24 A vehicle that is a dignified conveyance and was specified for use by the deceased
472.25 or by the family of the deceased may be used to transport the body to the place of final
472.26 disposition.

472.27 Sec. 63. Minnesota Statutes 2012, section 149A.94, is amended to read:
472.28 **149A.94 FINAL DISPOSITION.**
472.29 Subdivision 1. **Generally.** Every dead human body lying within the state, except
472.30 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
472.31 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
472.32 the state for the purpose of disposition elsewhere; and the remains of any dead human
472.33 body after dissection or anatomical study, shall be decently buried, or entombed in a

473.1 public or private cemetery, alkaline hydrolyzed or cremated, within a reasonable time
473.2 after death. Where final disposition of a body will not be accomplished within 72 hours
473.3 following death or release of the body by a competent authority with jurisdiction over the
473.4 body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body
473.5 may not be kept in refrigeration for a period exceeding six calendar days, or packed in dry
473.6 ice for a period that exceeds four calendar days, from the time of death or release of the
473.7 body from the coroner or medical examiner.

473.8 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, or
473.9 cremated without a disposition permit. The disposition permit must be filed with the person
473.10 in charge of the place of final disposition. Where a dead human body will be transported out
473.11 of this state for final disposition, the body must be accompanied by a certificate of removal.

473.12 Subd. 4. **Alkaline hydrolysis or cremation.** Inurnment of alkaline hydrolyzed or
473.13 cremated remains and release to an appropriate party is considered final disposition and no
473.14 further permits or authorizations are required for transportation, interment, entombment, or
473.15 placement of the cremated remains, except as provided in section 149A.95, subdivision 16.

473.16 Sec. 64. **[149A.941] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE**
473.17 **HYDROLYSIS.**

473.18 Subdivision 1. **License required.** A dead human body may only be hydrolyzed in
473.19 this state at an alkaline hydrolysis facility licensed by the commissioner of health.

473.20 Subd. 2. **General requirements.** Any building to be used as an alkaline hydrolysis
473.21 facility must comply with all applicable local and state building codes, zoning laws and
473.22 ordinances, wastewater management regulations, and environmental statutes, rules, and
473.23 standards. An alkaline hydrolysis facility must have, on site, a purpose built human
473.24 alkaline hydrolysis system approved by the commissioner of health, a system approved by
473.25 the commissioner of health for drying the hydrolyzed remains, a motorized mechanical
473.26 device approved by the commissioner of health for processing hydrolyzed remains and
473.27 must have in the building a holding facility approved by the commissioner of health for
473.28 the retention of dead human bodies awaiting alkaline hydrolysis. The holding facility
473.29 must be secure from access by anyone except the authorized personnel of the alkaline
473.30 hydrolysis facility, preserve the dignity of the remains, and protect the health and safety of
473.31 the alkaline hydrolysis facility personnel.

473.32 Subd. 3. **Lighting and ventilation.** The room where the alkaline hydrolysis vessel
473.33 is located and the room where the chemical storage takes place shall be properly lit and
473.34 ventilated with an exhaust fan that provides at least 12 air changes per hour.

474.1 Subd. 4. **Plumbing connections.** All plumbing fixtures, water supply lines,
474.2 plumbing vents, and waste drains shall be properly vented and connected pursuant to the
474.3 Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a
474.4 functional sink with hot and cold running water.

474.5 Subd. 5. **Flooring, walls, ceiling, doors, and windows.** The room where the
474.6 alkaline hydrolysis vessel is located and the room where the chemical storage takes place
474.7 shall have nonporous flooring, so that a sanitary condition is provided. The walls and
474.8 ceiling of the room where the alkaline hydrolysis vessel is located and the room where
474.9 the chemical storage takes place shall run from floor to ceiling and be covered with tile,
474.10 or by plaster or sheetrock painted with washable paint or other appropriate material so
474.11 that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be
474.12 constructed to prevent odors from entering any other part of the building. All windows
474.13 or other openings to the outside must be screened and all windows must be treated in a
474.14 manner that prevents viewing into the room where the alkaline hydrolysis vessel is located
474.15 and the room where the chemical storage takes place. A viewing window for authorized
474.16 family members or their designees is not a violation of this subdivision.

474.17 Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a
474.18 functional emergency eye wash and quick drench shower.

474.19 Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is
474.20 located and the room where the chemical storage takes place must be private and have no
474.21 general passageway through it. The room shall, at all times, be secure from the entrance of
474.22 unauthorized persons. Authorized persons are:

474.23 (1) licensed morticians;

474.24 (2) registered interns or students as described in section 149A.91, subdivision 6;

474.25 (3) public officials or representatives in the discharge of their official duties;

474.26 (4) trained alkaline hydrolysis facility operators; and

474.27 (5) the person(s) with the right to control the dead human body as defined in section
474.28 149A.80, subdivision 2, and their designees.

474.29 (b) Each door allowing ingress or egress shall carry a sign that indicates that the
474.30 room is private and access is limited. All authorized persons who are present in or enter
474.31 the room where the alkaline hydrolysis vessel is located while a body is being prepared for
474.32 final disposition must be attired according to all applicable state and federal regulations
474.33 regarding the control of infectious disease and occupational and workplace health and
474.34 safety.

474.35 Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline
474.36 hydrolysis vessel is located and the room where the chemical storage takes place and all

475.1 fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies
475.2 stored or used in the room must be maintained in a clean and sanitary condition at all times.

475.3 Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline
475.4 hydrolysis vessel for its operation, all state and local regulations for that boiler must be
475.5 followed.

475.6 Subd. 10. **Occupational and workplace safety.** All applicable provisions of state
475.7 and federal regulations regarding exposure to workplace hazards and accidents shall be
475.8 followed in order to protect the health and safety of all authorized persons at the alkaline
475.9 hydrolysis facility.

475.10 Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ
475.11 a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body.
475.12 It is the duty of the licensed alkaline hydrolysis facility to provide proper procedures for
475.13 all personnel, and the licensed alkaline hydrolysis facility shall be strictly accountable for
475.14 compliance with this chapter and other applicable state and federal regulations regarding
475.15 occupational and workplace health and safety.

475.16 Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility
475.17 shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part
475.18 without receiving written authorization to do so from the person or persons who have the
475.19 legal right to control disposition as described in section 149A.80 or the person's legal
475.20 designee. The written authorization must include:

475.21 (1) the name of the deceased and the date of death of the deceased;

475.22 (2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;

475.23 (3) the name, address, telephone number, relationship to the deceased, and signature
475.24 of the person or persons with legal right to control final disposition or a legal designee;

475.25 (4) directions for the disposition of any nonhydrolyzed materials or items recovered
475.26 from the alkaline hydrolysis vessel;

475.27 (5) acknowledgment that the hydrolyzed remains will be dried and mechanically
475.28 reduced to a granulated appearance and placed in an appropriate container and
475.29 authorization to place any hydrolyzed remains that a selected urn or container will not
475.30 accommodate into a temporary container;

475.31 (6) acknowledgment that, even with the exercise of reasonable care, it is not possible
475.32 to recover all particles of the hydrolyzed remains and that some particles may inadvertently
475.33 become commingled with particles of other hydrolyzed remains that remain in the alkaline
475.34 hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;

475.35 (7) directions for the ultimate disposition of the hydrolyzed remains; and

476.1 (8) a statement that includes, but is not limited to, the following information:
476.2 "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an
476.3 alkaline solution is used to chemically break down the human tissue and the hydrolyzable
476.4 alkaline hydrolysis container. After the process is complete, the liquid effluent solution
476.5 contains the chemical by-products of the alkaline hydrolysis process except for the
476.6 deceased's bone fragments. The solution is cooled and released according to local
476.7 environmental regulations. A water rinse is applied to the hydrolyzed remains which are
476.8 then dried and processed to facilitate inurnment or scattering."

476.9 Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in
476.10 good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an
476.11 authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from
476.12 civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis
476.13 facility.

476.14 Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be
476.15 accepted for final disposition by alkaline hydrolysis unless:
476.16 (1) encased in an appropriate alkaline hydrolysis container;
476.17 (2) accompanied by a disposition permit issued pursuant to section 149A.93,
476.18 subdivision 3, including a photocopy of the completed death record or a signed release
476.19 authorizing alkaline hydrolysis of the body received from the coroner or medical
476.20 examiner; and
476.21 (3) accompanied by an alkaline hydrolysis authorization that complies with
476.22 subdivision 12.
476.23 (b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline
476.24 hydrolysis container where there is:
476.25 (1) evidence of leakage of fluids from the alkaline hydrolysis container;
476.26 (2) a known dispute concerning hydrolysis of the body delivered;
476.27 (3) a reasonable basis for questioning any of the representations made on the written
476.28 authorization to hydrolyze; or
476.29 (4) any other lawful reason.

476.30 Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed
476.31 within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of
476.32 the body.

476.33 Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.**
476.34 All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for
476.35 dead human bodies shall use universal precautions and otherwise exercise all reasonable

477.1 precautions to minimize the risk of transmitting any communicable disease from the body.
477.2 No dead human body shall be removed from the container in which it is delivered.

477.3 Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall
477.4 develop, implement, and maintain an identification procedure whereby dead human
477.5 bodes can be identified from the time the alkaline hydrolysis facility accepts delivery
477.6 of the remains until the hydrolyzed remains are released to an authorized party. After
477.7 hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the
477.8 hydrolyzed remains container before the hydrolyzed remains are released from the alkaline
477.9 hydrolysis facility. Each identification disk, tab, or label shall have a number that shall
477.10 be recorded on all paperwork regarding the decedent. This procedure shall be designed
477.11 to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains
477.12 are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the
477.13 inability to individually identify the hydrolyzed remains is a violation of this subdivision.

477.14 Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline
477.15 hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains
477.16 in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for
477.17 infectious disease control.

477.18 Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of
477.19 dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is
477.20 written authorization from the person with the legal right to control the disposition,
477.21 only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline
477.22 hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting
477.23 alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline
477.24 hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.

477.25 Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains**
477.26 **prohibited.** Except with the express written permission of the person with the legal right
477.27 to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one
477.28 dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce
477.29 a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have
477.30 been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze
477.31 a dead human body and other human remains at the same time and in the same alkaline
477.32 hydrolysis vessel. This section does not apply where commingling of human remains
477.33 during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental
477.34 and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is
477.35 not a violation of this subdivision.

478.1 Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis**
478.2 **vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be
478.3 made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed
478.4 remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be
478.5 made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed
478.6 human remains and dispose of these materials in a lawful manner, by the alkaline
478.7 hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate
478.8 container to be transported to the processing area.
478.9 Subd. 22. **Drying device or mechanical processor procedures; commingling of**
478.10 **hydrolyzed remains prohibited.** Except with the express written permission of the
478.11 person with the legal right to control the final disposition or otherwise provided by
478.12 law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed
478.13 human remains of more than one body at a time in the same drying device or mechanical
478.14 processor, or introduce the hydrolyzed human remains of a second body into a drying
478.15 device or mechanical processor until processing of any preceding hydrolyzed human
478.16 remains has been terminated and reasonable efforts have been employed to remove all
478.17 fragments of the preceding hydrolyzed remains. The fact that there is incidental and
478.18 unavoidable residue in the drying device, the mechanical processor, or any container used
478.19 in a prior alkaline hydrolysis process, is not a violation of this provision.
478.20 Subd. 23. **Alkaline hydrolysis procedures; processing hydrolyzed remains.** The
478.21 hydrolyzed human remains shall be dried and then reduced by a motorized mechanical
478.22 device to a granulated appearance appropriate for final disposition and placed in an
478.23 alkaline hydrolysis remains container along with the appropriate identifying disk, tab,
478.24 or permanent label. Processing must take place within the licensed alkaline hydrolysis
478.25 facility. Dental gold, silver or amalgam, jewelry, or mementos, to the extent that they
478.26 can be identified, may be removed prior to processing the hydrolyzed remains, only by
478.27 staff licensed or registered by the commissioner of health; however, any dental gold and
478.28 silver, jewelry, or mementos that are removed shall be returned to the hydrolyzed remains
478.29 container unless otherwise directed by the person or persons having the right to control the
478.30 final disposition. Every person who removes or possesses dental gold or silver, jewelry,
478.31 or mementos from any hydrolyzed remains without specific written permission of the
478.32 person or persons having the right to control those remains is guilty of a misdemeanor.
478.33 The fact that residue and any unavoidable dental gold or dental silver, or other precious
478.34 metals remain in the alkaline hydrolysis vessel or other equipment or any container used
478.35 in a prior hydrolysis is not a violation of this section.

479.1 Subd. 24. **Alkaline hydrolysis procedures; container of insufficient capacity.**
479.2 If a hydrolyzed remains container is of insufficient capacity to accommodate all
479.3 hydrolyzed remains of a given dead human body, subject to directives provided in the
479.4 written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess
479.5 hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the
479.6 second container, in a manner so as not to be easily detached through incidental contact, to
479.7 the primary alkaline hydrolysis remains container. The secondary container shall contain a
479.8 duplicate of the identification disk, tab, or permanent label that was placed in the primary
479.9 container and all paperwork regarding the given body shall include a notation that the
479.10 hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature
479.11 hydrolyzed remains containers are not subject to the requirements of this subdivision.

479.12 Subd. 25. **Disposition procedures; commingling of hydrolyzed remains**
479.13 **prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in
479.14 a location where the hydrolyzed remains are commingled with those of another person
479.15 without the express written permission of the person with the legal right to control
479.16 disposition or as otherwise provided by law. This subdivision does not apply to the
479.17 scattering or burial of hydrolyzed remains at sea or in a body of water from individual
479.18 containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to
479.19 the disposal in a dedicated cemetery of accumulated residue removed from an alkaline
479.20 hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members
479.21 of the same family in a common container designed for the hydrolyzed remains of more
479.22 than one body, or to the inurnment in a container or interment in a space that has been
479.23 previously designated, at the time of sale or purchase, as being intended for the inurnment
479.24 or interment of the hydrolyzed remains of more than one person.

479.25 Subd. 26. **Alkaline hydrolysis procedures; disposition of accumulated residue.**
479.26 Every alkaline hydrolysis facility shall provide for the removal and disposition in a
479.27 dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel,
479.28 drying device, mechanical processor, container, or other equipment used in alkaline
479.29 hydrolysis. Disposition of accumulated residue shall be according to the regulations of the
479.30 dedicated cemetery and any applicable local ordinances.

479.31 Subd. 27. **Alkaline hydrolysis procedures; release of hydrolyzed remains.**
479.32 Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be
479.33 released according to the instructions given on the written authorization to hydrolyze. If
479.34 the hydrolyzed remains are to be shipped, they must be securely packaged and transported
479.35 by a method which has an internal tracing system available and which provides for a
479.36 receipt signed by the person accepting delivery. Where there is a dispute over release

480.1 or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit
480.2 the hydrolyzed remains with a court of competent jurisdiction pending resolution of the
480.3 dispute or retain the hydrolyzed remains until the person with the legal right to control
480.4 disposition presents satisfactory indication that the dispute is resolved.

480.5 Subd. 28. **Unclaimed hydrolyzed remains.** If, after 30 calendar days following
480.6 the inurnment, the hydrolyzed remains are not claimed or disposed of according to the
480.7 written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment
480.8 may give written notice, by certified mail, to the person with the legal right to control
480.9 the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and
480.10 requesting further release directions. Should the hydrolyzed remains be unclaimed 120
480.11 calendar days following the mailing of the written notification, the alkaline hydrolysis
480.12 facility or funeral establishment may dispose of the hydrolyzed remains in any lawful
480.13 manner deemed appropriate.

480.14 Subd. 29. **Required records.** Every alkaline hydrolysis facility shall create and
480.15 maintain on its premises or other business location in Minnesota an accurate record of
480.16 every hydrolyzation provided. The record shall include all of the following information
480.17 for each hydrolyzation:

480.18 (1) the name of the person or funeral establishment delivering the body for alkaline
480.19 hydrolysis;

480.20 (2) the name of the deceased and the identification number assigned to the body;

480.21 (3) the date of acceptance of delivery;

480.22 (4) the names of the alkaline hydrolysis vessel, drying device, and mechanical
480.23 processor operator;

480.24 (5) the time and date that the body was placed in and removed from the alkaline
480.25 hydrolysis vessel;

480.26 (6) the time and date that processing and inurnment of the hydrolyzed remains
480.27 was completed;

480.28 (7) the time, date, and manner of release of the hydrolyzed remains;

480.29 (8) the name and address of the person who signed the authorization to hydrolyze;

480.30 (9) all supporting documentation, including any transit or disposition permits, a
480.31 photocopy of the death record, and the authorization to hydrolyze; and

480.32 (10) the type of alkaline hydrolysis container.

480.33 Subd. 30. **Retention of records.** Records required under subdivision 29 shall be
480.34 maintained for a period of three calendar years after the release of the hydrolyzed remains.
480.35 Following this period and subject to any other laws requiring retention of records, the
480.36 alkaline hydrolysis facility may then place the records in storage or reduce them to

481.1 microfilm, microfiche, laser disc, or any other method that can produce an accurate
481.2 reproduction of the original record, for retention for a period of ten calendar years from
481.3 the date of release of the hydrolyzed remains. At the end of this period and subject to any
481.4 other laws requiring retention of records, the alkaline hydrolysis facility may destroy
481.5 the records by shredding, incineration, or any other manner that protects the privacy of
481.6 the individuals identified.

481.7 Sec. 65. Minnesota Statutes 2012, section 149A.96, subdivision 9, is amended to read:
481.8 Subd. 9. **Hydrolyzed and cremated remains.** Subject to section 149A.95,
481.9 subdivision 16, inurnment of the hydrolyzed or cremated remains and release to an
481.10 appropriate party is considered final disposition and no further permits or authorizations
481.11 are required for disinterment, transportation, or placement of the hydrolyzed or cremated
481.12 remains.

481.13 Sec. 66. **REVISOR'S INSTRUCTION.**
481.14 The revisor shall substitute the term "vertical heat exchangers" or "vertical
481.15 heat exchanger" with "bored geothermal heat exchangers" or "bored geothermal heat
481.16 exchanger" wherever it appears in Minnesota Statutes, sections 103I.005, subdivisions
481.17 2 and 12; 103I.101, subdivisions 2 and 5; 103I.105; 103I.205, subdivision 4; 103I.208,
481.18 subdivision 2; 103I.501; 103I.531, subdivision 5; and 103I.641, subdivisions 1, 2, and 3.

481.19 Sec. 67. **REPEALER.**
481.20 (a) Minnesota Statutes 2012, sections 103I.005, subdivision 20; 149A.025; 149A.20,
481.21 subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6;
481.22 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53,
481.23 subdivision 9; and 485.14, are repealed.
481.24 (b) Minnesota Statutes 2012, section 144.123, subdivision 2, is repealed effective
481.25 July 1, 2014.

481.26 **ARTICLE 14**

481.27 **HUMAN SERVICES FORECAST ADJUSTMENTS**

481.28 Section 1. **SUMMARY OF APPROPRIATIONS.**
481.29 The amounts shown in this section summarize direct appropriations, by fund, made
481.30 in this article.

481.31		2014		2015		Total
481.32 General	$	5,648,596,000	$	5,914,450,000	$	11,563,046,000

State Government Special Revenue	70,996,000	73,066,000	144,062,000
Health Care Access	597,449,000	424,738,000	1,022,187,000
Federal TANF	269,628,000	266,526,000	536,154,000
Lottery Prize Fund	1,665,000	1,665,000	3,330,000
Total	**$ 6,588,334,000**	**$ 6,680,445,000**	**$ 13,268,779,000**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ (161,031,000)**

Appropriations by Fund	
	2013
General Fund	(158,668,000)
Health Care Access	(7,179,000)
TANF	4,816,000

Subd. 2. **Forecasted Programs**

(a) **MFIP/DWP Grants**

Appropriations by Fund	
General Fund	(8,211,000)
TANF	4,399,000

(b) **MFIP Child Care Assistance Grants** 10,113,000

(c) **General Assistance Grants** 3,230,000

(d) **Minnesota Supplemental Aid Grants** (1,008,000)

(e) **Group Residential Housing Grants** (5,423,000)

(f) **MinnesotaCare Grants** (7,179,000)

This appropriation is from the health care access fund.

(g) **Medical Assistance Grants** (159,733,000)

(h) **Alternative Care Grants** -0-

(i) **CD Entitlement Grants** 2,364,000

Subd. 3. **Technical Activities** 417,000

This appropriation is from the TANF fund.

Sec. 3. **EFFECTIVE DATE.**

483.1 Sections 1 and 2 are effective the day following final enactment.

483.2 ARTICLE 15

483.3 HEALTH AND HUMAN SERVICES APPROPRIATIONS

483.4 Section 1. **SUMMARY OF APPROPRIATIONS.**

483.5 The amounts shown in this section summarize direct appropriations, by fund, made
483.6 in this article.

		2014		2015		Total
483.7		**2014**		**2015**		**Total**
483.8 General	$	5,648,596,000	$	5,914,450,000	$	11,563,046,000
483.9 State Government Special 483.10 Revenue		70,996,000		73,066,000		144,062,000
483.11 Health Care Access		597,449,000		424,738,000		1,022,187,000
483.12 Federal TANF		269,628,000		266,526,000		536,154,000
483.13 Lottery Prize Fund		1,665,000		1,665,000		3,330,000
483.14 **Total**	**$**	**6,588,334,000**	**$**	**6,680,445,000**	**$**	**13,268,779,000**

483.15 Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

483.16 The sums shown in the columns marked "Appropriations" are appropriated to the
483.17 agencies and for the purposes specified in this article. The appropriations are from the
483.18 general fund, or another named fund, and are available for the fiscal years indicated
483.19 for each purpose. The figures "2014" and "2015" used in this article mean that the
483.20 appropriations listed under them are available for the fiscal year ending June 30, 2014, or
483.21 June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal
483.22 year 2015. "The biennium" is fiscal years 2014 and 2015.

483.23 **APPROPRIATIONS**
483.24 **Available for the Year**
483.25 **Ending June 30**
483.26 **2014** **2015**

483.27 Sec. 3. **COMMISSIONER OF HUMAN**
483.28 **SERVICES**

		2014		2015
483.29 Subdivision 1. **Total Appropriation**	**$**	**6,460,239,000**	**$**	**6,493,273,000**

483.30 Appropriations by Fund

	2014	2015
483.31	2014	2015
483.32 General	5,565,387,000	5,836,434,000
483.33 State Government 483.34 Special Revenue	4,065,000	6,265,000
483.35 Health Care Access	631,207,000	394,096,000

484.1 Federal TANF	257,915,000	254,813,000
484.2 Lottery Prize Fund	1,665,000	1,665,000

484.3 **Receipts for Systems Projects.**
484.4 Appropriations and federal receipts for
484.5 information systems projects for MAXIS,
484.6 PRISM, MMIS, and SSIS must be deposited
484.7 in the state system account authorized
484.8 in Minnesota Statutes, section 256.014.
484.9 Money appropriated for computer projects
484.10 approved by the commissioner of Minnesota
484.11 information technology services, funded
484.12 by the legislature, and approved by the
484.13 commissioner of management and budget,
484.14 may be transferred from one project to
484.15 another and from development to operations
484.16 as the commissioner of human services
484.17 considers necessary. Any unexpended
484.18 balance in the appropriation for these
484.19 projects does not cancel but is available for
484.20 ongoing development and operations.

484.21 **Nonfederal Share Transfers.** The
484.22 nonfederal share of activities for which
484.23 federal administrative reimbursement is
484.24 appropriated to the commissioner may be
484.25 transferred to the special revenue fund.

484.26 **ARRA Supplemental Nutrition Assistance**
484.27 **Benefit Increases.** The funds provided for
484.28 food support benefit increases under the
484.29 Supplemental Nutrition Assistance Program
484.30 provisions of the American Recovery and
484.31 Reinvestment Act (ARRA) of 2009 must be
484.32 used for benefit increases beginning July 1,
484.33 2009.

484.34 **Supplemental Nutrition Assistance**
484.35 **Program Employment and Training.**

485.1 (1) Notwithstanding Minnesota Statutes,
485.2 sections 256D.051, subdivisions 1a, 6b,
485.3 and 6c, and 256J.626, federal Supplemental
485.4 Nutrition Assistance employment and
485.5 training funds received as reimbursement of
485.6 MFIP consolidated fund grant expenditures
485.7 for diversionary work program participants
485.8 and child care assistance program
485.9 expenditures must be deposited in the general
485.10 fund. The amount of funds must be limited to
485.11 $4,900,000 per year in fiscal years 2014 and
485.12 2015, and to $4,400,000 per year in fiscal
485.13 years 2016 and 2017, contingent on approval
485.14 by the federal Food and Nutrition Service.

485.15 (2) Consistent with the receipt of the federal
485.16 funds, the commissioner may adjust the
485.17 level of working family credit expenditures
485.18 claimed as TANF maintenance of effort.
485.19 Notwithstanding any contrary provision in
485.20 this article, this rider expires June 30, 2017.

485.21 **TANF Maintenance of Effort.** (a) In order
485.22 to meet the basic maintenance of effort
485.23 (MOE) requirements of the TANF block grant
485.24 specified under Code of Federal Regulations,
485.25 title 45, section 263.1, the commissioner may
485.26 only report nonfederal money expended for
485.27 allowable activities listed in the following
485.28 clauses as TANF/MOE expenditures:

485.29 (1) MFIP cash, diversionary work program,
485.30 and food assistance benefits under Minnesota
485.31 Statutes, chapter 256J;

485.32 (2) the child care assistance programs
485.33 under Minnesota Statutes, sections 119B.03
485.34 and 119B.05, and county child care

486.1 administrative costs under Minnesota
486.2 Statutes, section 119B.15;

486.3 (3) state and county MFIP administrative
486.4 costs under Minnesota Statutes, chapters
486.5 256J and 256K;

486.6 (4) state, county, and tribal MFIP
486.7 employment services under Minnesota
486.8 Statutes, chapters 256J and 256K;

486.9 (5) expenditures made on behalf of legal
486.10 noncitizen MFIP recipients who qualify for
486.11 the MinnesotaCare program under Minnesota
486.12 Statutes, chapter 256L;

486.13 (6) qualifying working family credit
486.14 expenditures under Minnesota Statutes,
486.15 section 290.0671;

486.16 (7) qualifying Minnesota education credit
486.17 expenditures under Minnesota Statutes,
486.18 section 290.0674; and

486.19 (8) qualifying Head Start expenditures under
486.20 Minnesota Statutes, section 119A.50.

486.21 (b) The commissioner shall ensure that
486.22 sufficient qualified nonfederal expenditures
486.23 are made each year to meet the state's
486.24 TANF/MOE requirements. For the activities
486.25 listed in paragraph (a), clauses (2) to
486.26 (8), the commissioner may only report
486.27 expenditures that are excluded from the
486.28 definition of assistance under Code of
486.29 Federal Regulations, title 45, section 260.31.

486.30 (c) For fiscal years beginning with state fiscal
486.31 year 2003, the commissioner shall ensure
486.32 that the maintenance of effort used by the
486.33 commissioner of management and budget
486.34 for the February and November forecasts

487.1 required under Minnesota Statutes, section
487.2 16A.103, contains expenditures under
487.3 paragraph (a), clause (1), equal to at least 16
487.4 percent of the total required under Code of
487.5 Federal Regulations, title 45, section 263.1.

487.6 (d) The requirement in Minnesota Statutes,
487.7 section 256.011, subdivision 3, that federal
487.8 grants or aids secured or obtained under that
487.9 subdivision be used to reduce any direct
487.10 appropriations provided by law, do not apply
487.11 if the grants or aids are federal TANF funds.

487.12 (e) For the federal fiscal years beginning on
487.13 or after October 1, 2007, the commissioner
487.14 may not claim an amount of TANF/MOE in
487.15 excess of the 75 percent standard in Code
487.16 of Federal Regulations, title 45, section
487.17 263.1(a)(2), except:

487.18 (1) to the extent necessary to meet the 80
487.19 percent standard under Code of Federal
487.20 Regulations, title 45, section 263.1(a)(1),
487.21 if it is determined by the commissioner
487.22 that the state will not meet the TANF work
487.23 participation target rate for the current year;

487.24 (2) to provide any additional amounts
487.25 under Code of Federal Regulations, title 45,
487.26 section 264.5, that relate to replacement of
487.27 TANF funds due to the operation of TANF
487.28 penalties; and

487.29 (3) to provide any additional amounts that
487.30 may contribute to avoiding or reducing
487.31 TANF work participation penalties through
487.32 the operation of the excess MOE provisions
487.33 of Code of Federal Regulations, title 45,
487.34 section 261.43(a)(2).

488.1 For the purposes of clauses (1) to (3),
488.2 the commissioner may supplement the
488.3 MOE claim with working family credit
488.4 expenditures or other qualified expenditures
488.5 to the extent such expenditures are otherwise
488.6 available after considering the expenditures
488.7 allowed in this subdivision and subdivisions
488.8 2 and 3.

488.9 (f) Notwithstanding any contrary provision
488.10 in this article, paragraphs (a) to (e) expire
488.11 June 30, 2017.

488.12 **Working Family Credit Expenditures**
488.13 **as TANF/MOE.** The commissioner may
488.14 claim as TANF maintenance of effort up to
488.15 $6,707,000 per year of working family credit
488.16 expenditures in each fiscal year.

488.17 Subd. 2. **Working Family Credit to be Claimed**
488.18 **for TANF/MOE**

488.19 The commissioner may count the following
488.20 amounts of working family credit
488.21 expenditures as TANF/MOE:

488.22 (1) fiscal year 2014, $43,576,000; and

488.23 (2) fiscal year 2015, $43,548,000.

488.24 Subd. 3. **TANF Transfer to Federal Child Care**
488.25 **and Development Fund**

488.26 (a) The following TANF fund amounts
488.27 are appropriated to the commissioner for
488.28 purposes of MFIP/transition year child care
488.29 assistance under Minnesota Statutes, section
488.30 119B.05:

488.31 (1) fiscal year 2014; $14,020,000; and

488.32 (2) fiscal year 2015, $14,020,000.

488.33 (b) The commissioner shall authorize the
488.34 transfer of sufficient TANF funds to the

489.1 federal child care and development fund to
489.2 meet this appropriation and shall ensure that
489.3 all transferred funds are expended according
489.4 to federal child care and development fund
489.5 regulations.

489.6 Subd. 4. **Central Office**

489.7 The amounts that may be spent from this
489.8 appropriation for each purpose are as follows:

489.9 **(a) Operations**

489.10 Appropriations by Fund

489.11 General	98,727,000	94,277,000
489.12 State Government 489.13 Special Revenue	3,940,000	6,140,000
489.14 Health Care Access	13,177,000	13,004,000
489.15 Federal TANF	100,000	100,000

489.16 **Reform 2020 Contingency.** The
489.17 appropriation from the general fund may
489.18 be adjusted as provided in article 2, section
489.19 49, in order to implement Reform 2020 and
489.20 systems modernization.

489.21 **DHS Receipt Center Accounting.** The
489.22 commissioner is authorized to transfer
489.23 appropriations to, and account for DHS
489.24 receipt center operations in, the special
489.25 revenue fund.

489.26 **Administrative Recovery; Set-Aside.** The
489.27 commissioner may invoice local entities
489.28 through the SWIFT accounting system as an
489.29 alternative means to recover the actual cost
489.30 of administering the following provisions:

489.31 (1) Minnesota Statutes, section 125A.744,
489.32 subdivision 3;

489.33 (2) Minnesota Statutes, section 245.495,
489.34 paragraph (b);

490.1 (3) Minnesota Statutes, section 256B.0625,
490.2 subdivision 20, paragraph (k);

490.3 (4) Minnesota Statutes, section 256B.0924,
490.4 subdivision 6, paragraph (g);

490.5 (5) Minnesota Statutes, section 256B.0945,
490.6 subdivision 4, paragraph (d); and

490.7 (6) Minnesota Statutes, section 256F.10,
490.8 subdivision 6, paragraph (b).

490.9 **Systems Modernization.** The following
490.10 amounts are appropriated for transfer to
490.11 the state systems account authorized in
490.12 Minnesota Statutes, section 256.014:

490.13 (1) $1,825,000 in fiscal year 2014 and
490.14 $2,502,000 in fiscal year 2015 is for the
490.15 state share of Medicaid-allocated costs of
490.16 the health insurance exchange information
490.17 technology and operational structure. The
490.18 funding base is $3,222,000 in fiscal year 2016
490.19 and $3,037,000 in fiscal year 2017 but shall
490.20 not be included in the base thereafter; and

490.21 (2) $6,662,000 in fiscal year 2014 and
490.22 $1,148,000 in fiscal year 2015 are for the
490.23 modernization and streamlining of agency
490.24 eligibility and child support systems. The
490.25 funding base is $5,921,000 in fiscal year
490.26 2016 and $1,792,000 in fiscal year 2017 but
490.27 shall not be included in the base thereafter.

490.28 The unexpended balance of the $6,662,000
490.29 appropriation in fiscal year 2014 and the
490.30 $1,148,000 appropriation in fiscal year 2015
490.31 must be transferred from the Department of
490.32 Human Services state systems account to
490.33 the Office of Enterprise Technology when
490.34 the Office of Enterprise Technology has

491.1 negotiated a federally approved internal
491.2 service fund rates and billing process with
491.3 sufficient internal accounting controls to
491.4 properly maximize federal reimbursement
491.5 to Minnesota for human services system
491.6 modernization projects, but not later than
491.7 June 30, 2015.

491.8 If contingent funding is fully or partially
491.9 disbursed under article 2, section 49, and
491.10 transferred to the state systems account, the
491.11 unexpended balance of that appropriation
491.12 must be transferred to the Office of Enterprise
491.13 Technology in accordance with this clause.
491.14 Contingent funding must not exceed
491.15 $16,992,000 for the biennium.

491.16 **Base Adjustment.** The general fund base
491.17 is increased by $6,099,000 in fiscal year
491.18 2016 and $1,185,000 in fiscal year 2017.
491.19 The health access fund base is decreased by
491.20 $551,000 in fiscal years 2016 and 2017.

491.21 **(b) Children and Families**

491.22	Appropriations by Fund		
491.23	General	8,082,000	8,018,000
491.24	Federal TANF	2,282,000	2,282,000

491.25 **Reform 2020 Contingency.** The
491.26 appropriation from the general fund may be
491.27 adjusted as provided in article 2, section 49,
491.28 in order to implement Reform 2020.

491.29 **Financial Institution Data Match and**
491.30 **Payment of Fees.** The commissioner is
491.31 authorized to allocate up to $310,000 each
491.32 year in fiscal years 2014 and 2015 from the
491.33 PRISM special revenue account to make
491.34 payments to financial institutions in exchange
491.35 for performing data matches between account

492.1 information held by financial institutions
492.2 and the public authority's database of child
492.3 support obligors as authorized by Minnesota
492.4 Statutes, section 13B.06, subdivision 7.

492.5 **Base Adjustment.** The general fund base is
492.6 decreased by $300,000 in fiscal years 2016
492.7 and 2017, and the federal TANF fund base is
492.8 increased by $300,000 in fiscal years 2016
492.9 and 2017.

492.10 **(c) Health Care**

492.11	Appropriations by Fund		
492.12	General	13,843,000	13,639,000
492.13	Health Care Access	26,404,000	29,914,000

492.14 **Base Adjustment.** The health care access
492.15 fund base is increased by $8,177,000 in fiscal
492.16 year 2016 and by $6,712,000 in fiscal year
492.17 2017.

492.18 **(d) Continuing Care**

492.19	Appropriations by Fund		
492.20	General	19,503,000	21,044,000
492.21 492.22	State Government Special Revenue	125,000	125,000

492.23 **Reform 2020 Contingency.** The
492.24 appropriation from the general fund may be
492.25 adjusted as provided in article 2, section 49,
492.26 in order to implement Reform 2020.

492.27 **Base Adjustment.** The general fund base is
492.28 increased by $3,324,000 in fiscal year 2016
492.29 and by $3,324,000 in fiscal year 2017.

492.30 **(e) Chemical and Mental Health**

492.31	Appropriations by Fund		
492.32	General	4,494,000	4,294,000
492.33	Lottery Prize Fund	157,000	157,000

492.34 Subd. 5. **Forecasted Programs**

493.1 The amounts that may be spent from this
493.2 appropriation for each purpose are as follows:

493.3 **(a) MFIP/DWP**

493.4	Appropriations by Fund		
493.5	General	73,742,000	75,261,000
493.6	Federal TANF	80,342,000	76,851,000

493.7	**(b) MFIP Child Care Assistance**	64,316,000	68,536,000
493.8	**(c) General Assistance**	54,787,000	56,068,000

493.9 **General Assistance Standard.** The
493.10 commissioner shall set the monthly standard
493.11 of assistance for general assistance units
493.12 consisting of an adult recipient who is
493.13 childless and unmarried or living apart
493.14 from parents or a legal guardian at $203.
493.15 The commissioner may reduce this amount
493.16 according to Laws 1997, chapter 85, article
493.17 3, section 54.

493.18 **Emergency General Assistance.** The
493.19 amount appropriated for emergency general
493.20 assistance funds is limited to no more
493.21 than $6,729,812 in fiscal year 2014 and
493.22 $6,729,812 in fiscal year 2015. Funds
493.23 to counties shall be allocated by the
493.24 commissioner using the allocation method in
493.25 Minnesota Statutes, section 256D.06.

493.26	**(d) MN Supplemental Assistance**	38,646,000	39,821,000
493.27	**(e) Group Residential Housing**	141,138,000	150,988,000

493.28 **Reform 2020 Contingency.** The
493.29 appropriation from the general fund may be
493.30 adjusted as provided in article 2, section 49,
493.31 in order to implement Reform 2020.

493.32 **(f) MinnesotaCare**

493.33	Health Care Access	296,581,000	227,598,000

494.1 **(g) Medical Assistance**

494.2	Appropriations by Fund		
494.3	General	4,348,570,000	4,602,815,000
494.4	Health Care Access	292,067,000	121,417,000

494.5 **Reform 2020 Contingency.** The
494.6 appropriation from the general fund may be
494.7 adjusted as provided in article 2, section 49,
494.8 in order to implement Reform 2020.

494.9	**(h) Alternative Care**	46,653,000	44,500,000

494.10 **Reform 2020 Contingency.** The
494.11 appropriation from the general fund may be
494.12 adjusted as provided in article 2, section 49,
494.13 in order to implement Reform 2020.

494.14 **Alternative Care Transfer.** Any money
494.15 allocated to the alternative care program that
494.16 is not spent for the purposes indicated does
494.17 not cancel but shall be transferred to the
494.18 medical assistance account.

494.19	**(i) CD Treatment Fund**	81,440,000	74,875,000

494.20 **Balance Transfer.** The commissioner must
494.21 transfer $18,188,000 from the consolidated
494.22 chemical dependency treatment fund to the
494.23 general fund by September 30, 2013.

494.24 Subd. 6. **Grant Programs**

494.25 The amounts that may be spent from this
494.26 appropriation for each purpose are as follows:

494.27 **(a) Support Services Grants**

494.28	Appropriations by Fund		
494.29	General	13,333,000	13,333,000
494.30	Federal TANF	94,611,000	94,611,000

494.31 **Paid Work Experience.** $2,168,000 each
494.32 year is from the general fund for paid work
494.33 experience for long-term MFIP recipients.

495.1 Paid work includes full and partial wage
495.2 subsidies and other related services such as
495.3 job development, marketing, preworksite
495.4 training, job coaching, and postplacement
495.5 services. These are onetime appropriations.
495.6 Unexpended funds for fiscal year 2014 do not
495.7 cancel but are available to the commissioner
495.8 for this purpose in fiscal year 2015.

495.9 **Work Study Funding for MFIP**
495.10 **Participants.** $250,000 each year is from
495.11 the general fund to pilot work study jobs for
495.12 MFIP recipients in approved postsecondary
495.13 education programs. This is a onetime
495.14 appropriation. Unexpended funds for fiscal
495.15 year 2014 do not cancel but are available for
495.16 this purpose in fiscal year 2015.

495.17 **Local Strategies to Reduce Disparities.**
495.18 $2,000,000 each year is from the general
495.19 fund, for local projects that focus on services
495.20 for subgroups within the MFIP caseload
495.21 who are experiencing poor employment
495.22 outcomes. These are onetime appropriations.
495.23 Unexpended funds for fiscal year 2014 do not
495.24 cancel but are available to the commissioner
495.25 for this purpose in fiscal year 2015.

495.26 **Home Visiting Collaborations for MFIP**
495.27 **Teen Parents.** $200,000 each year is from
495.28 the general fund for technical assistance and
495.29 training to support local collaborations that
495.30 provide home visiting services for MFIP teen
495.31 parents. The TANF fund base is increased by
495.32 $200,000 in fiscal years 2016 and 2017.

495.33 **Performance Bonus Funds for Counties.**
495.34 The TANF fund base is increased by
495.35 $1,500,000 each year in fiscal years 2016

496.1 and 2017. The commissioner must allocate
496.2 this amount each year to counties that exceed
496.3 their expected range of performance on the
496.4 annualized three-year self-support index
496.5 as defined in Minnesota Statutes, section
496.6 256J.751, subdivision 2, clause (6). This is a
496.7 permanent base adjustment. Notwithstanding
496.8 any contrary provisions in this article, this
496.9 provision expires June 30, 2016.

496.10 **Base Adjustment.** The general fund base is
496.11 decreased by $4,618,000 in fiscal years 2016
496.12 and 2017. The TANF fund base is increased
496.13 by $1,700,000 in fiscal years 2016 and 2017.

496.14 **(b) Basic Sliding Fee Child Care Assistance** 496.15 **Grants**	40,351,000	43,658,000

496.16 **Base Adjustment.** The general fund base is
496.17 increased by $1,278,000 in fiscal year 2016
496.18 and by $1,349,000 in fiscal year 2017.

496.19 **(c) Child Care Development Grants**	1,737,000	1,987,000
496.20 **(d) Child Support Enforcement Grants**	50,000	50,000

496.21 **Federal Child Support Demonstration**
496.22 **Grants.** Federal administrative
496.23 reimbursement resulting from the federal
496.24 child support grant expenditures authorized
496.25 under United States Code, title 42, section
496.26 1315, is appropriated to the commissioner
496.27 for this activity.

496.28 **(e) Children's Services Grants**

496.29	Appropriations by Fund	
496.30 General	49,688,000	52,337,000
496.31 Federal TANF	140,000	140,000

496.32 **Adoption Assistance and Relative Custody**
496.33 **Assistance.** The commissioner may transfer
496.34 unencumbered appropriation balances for

497.1 adoption assistance and relative custody
497.2 assistance between fiscal years and between
497.3 programs.

497.4 **Privatized Adoption Grants.** Federal
497.5 reimbursement for privatized adoption grant
497.6 and foster care recruitment grant expenditures
497.7 is appropriated to the commissioner for
497.8 adoption grants and foster care and adoption
497.9 administrative purposes.

497.10 **Adoption Assistance Incentive Grants.**
497.11 Federal funds available during fiscal years
497.12 2014 and 2015 for adoption incentive grants
497.13 are appropriated to the commissioner for
497.14 these purposes.

497.15 **Base Adjustment.** The general fund base is
497.16 increased by $5,139,000 in fiscal year 2016
497.17 and by $9,155,000 in fiscal year 2017.

497.18 **(f) Child and Community Service Grants**	53,301,000	53,301,000

497.19 **Reform 2020 Contingency.** The
497.20 appropriation from the general fund may be
497.21 adjusted as provided in article 2, section 49,
497.22 in order to implement Reform 2020.

497.23 **(g) Child and Economic Support Grants**	18,897,000	18,903,000

497.24 **Minnesota Food Assistance Program.**
497.25 Unexpended funds for the Minnesota food
497.26 assistance program for fiscal year 2014 do
497.27 not cancel but are available for this purpose
497.28 in fiscal year 2015.

497.29 **Family Assets for Independence.** $250,000
497.30 each year is for the Family Assets for
497.31 Independence Minnesota program. This
497.32 appropriation is available in either year of the
497.33 biennium and may be transferred between

498.1 fiscal years. This appropriation is added to
498.2 the base.

498.3 **(h) Health Care Grants**

498.4 Appropriations by Fund

General	90,000	90,000
Health Care Access	2,228,000	1,413,000

498.7 **Base Adjustment.** The health care access
498.8 fund is decreased by $1,223,000 in fiscal
498.9 years 2016 and 2017.

498.10 **(i) Aging and Adult Services Grants** 22,143,000 23,009,000

498.11 **Reform 2020 Contingency.** The
498.12 appropriation from the general fund may be
498.13 adjusted as provided in article 2, section 49,
498.14 in order to implement Reform 2020.

498.15 **Gaps Analysis.** In fiscal year 2014, and
498.16 in each even-numbered year thereafter,
498.17 $435,000 is appropriated to conduct an
498.18 analysis of gaps in long-term care services
498.19 under Minnesota Statutes, section 144A.351.
498.20 This is a biennial appropriation. The base is
498.21 increased by $435,000 in fiscal year 2016.
498.22 Notwithstanding any contrary provisions in
498.23 this article, this provision does not expire.

498.24 **(j) Deaf and Hard-of-Hearing Grants** 1,767,000 1,767,000

498.25 **(k) Disabilities Grants** 18,048,000 18,271,000

498.26 **Reform 2020 Contingency.** The
498.27 appropriation from the general fund may be
498.28 adjusted as provided in article 2, section 49,
498.29 in order to implement Reform 2020.

498.30 **Base Adjustment.** The general fund base
498.31 is increased by $502,000 in fiscal year 2016
498.32 and by $676,000 in fiscal year 2017.

498.33 **(l) Adult Mental Health Grants**

499.1 Appropriations by Fund

499.2 General	70,617,000	68,803,000
499.3 Health Care Access	750,000	750,000
499.4 Lottery Prize	1,508,000	1,508,000

499.5 **Funding Usage.** Up to 75 percent of a fiscal
499.6 year's appropriations for adult mental health
499.7 grants may be used to fund allocations in that
499.8 portion of the fiscal year ending December
499.9 31.

499.10 **Base Adjustment.** The general fund base is
499.11 decreased by $4,461,000 in fiscal years 2016
499.12 and 2017.

499.13 **(m) Child Mental Health Grants** 17,599,000 19,988,000

499.14 **Funding Usage.** Up to 75 percent of a fiscal
499.15 year's appropriation for child mental health
499.16 grants may be used to fund allocations in that
499.17 portion of the fiscal year ending December
499.18 31.

499.19 **(n) CD Treatment Support Grants** 1,636,000 1,636,000

499.20 **SBIRT Training.** $300,000 each year is
499.21 for grants to train primary care clinicians to
499.22 provide substance abuse brief intervention
499.23 and referral to treatment (SBIRT). This is a
499.24 onetime appropriation.

499.25 **Base Adjustment.** The general fund base is
499.26 decreased by $300,000 in fiscal years 2016
499.27 and 2017.

499.28 Subd. 7. **State-Operated Services** 185,420,000 185,420,000

499.29 **Transfer Authority Related to**
499.30 **State-Operated Services.** Money
499.31 appropriated for state-operated services
499.32 may be transferred between fiscal years
499.33 of the biennium with the approval of the
499.34 commissioner of management and budget.

500.1 The amounts that may be spent from the
500.2 appropriation for each purpose are as follows:

500.3 **(a) SOS Mental Health**	115,838,000	115,838,000

500.4 **Dedicated Receipts Available.** Of the
500.5 revenue received under Minnesota Statutes,
500.6 section 246.18, subdivision 8, paragraph
500.7 (a), $1,000,000 each year is available for
500.8 the purposes of paragraph (b), clause (1),
500.9 of that subdivision, $1,000,000 each year
500.10 is available to transfer to the adult mental
500.11 health budget activity for the purposes of
500.12 paragraph (b), clause (2), of that subdivision,
500.13 and up to $2,713,000 each year is available
500.14 for the purposes of paragraph (b), clause (3),
500.15 of that subdivision.

500.16 **(b) SOS MN Security Hospital**	69,582,000	69,582,000
500.17 Subd. 8. **Sex Offender Program**	76,769,000	79,745,000

500.18 **Transfer Authority Related to Minnesota**
500.19 **Sex Offender Program.** Money
500.20 appropriated for the Minnesota sex offender
500.21 program may be transferred between fiscal
500.22 years of the biennium with the approval of the
500.23 commissioner of management and budget.

500.24 Subd. 9. **Technical Activities**	79,340,000	79,429,000

500.25 This appropriation is from the federal TANF
500.26 fund.

500.27 **Base Adjustment.** The federal TANF fund
500.28 base is decreased by $22,000 in fiscal year
500.29 2016 and by $49,000 in fiscal year 2017.

500.30 Subd. 10. **Transfer.**

500.31 The commissioner of management and
500.32 budget must transfer $65,000,000 in fiscal

501.1 year 2014 from the general fund to the health
501.2 care access fund. This is a onetime transfer.

501.3 Sec. 4. **COMMISSIONER OF HEALTH**

501.4 Subdivision 1. **Total Appropriation** **$ 170,327,000 $ 165,095,000**

501.5 Appropriations by Fund

501.6		2014	2015
501.7	General	77,857,000	72,664,000
501.8 501.9	State Government Special Revenue	50,203,000	50,123,000
501.10	Health Care Access	31,242,000	30,642,000
501.11	Federal TANF	11,713,000	11,713,000

501.12 The amounts that may be spent for each
501.13 purpose are specified in the following
501.14 subdivisions.

501.15 Subd 2. **Health Improvement**

501.16 Appropriations by Fund

501.17	General	51,245,000	46,052,000
501.18 501.19	State Government Special Revenue	1,033,000	1,033,000
501.20	Health Care Access	21,719,000	21,719,000
501.21	Federal TANF	11,713,000	11,713,000

501.22 **Statewide Health Improvement Program.**
501.23 $20,000,000 in fiscal year 2014 and
501.24 $20,000,000 in fiscal year 2015 are
501.25 appropriated from the health care access
501.26 fund for the statewide health improvement
501.27 program under Minnesota Statutes, section
501.28 145.986.

501.29 **Statewide Cancer Surveillance System.**
501.30 Of the general fund appropriation, $350,000
501.31 in fiscal year 2014 and $350,000 in fiscal
501.32 year 2015 are appropriated to develop and
501.33 implement a new cancer reporting system
501.34 under Minnesota Statutes, sections 144.671
501.35 to 144.69. Any information technology
501.36 development or support costs necessary

502.1 for the cancer surveillance system must
502.2 be incorporated into the agency's service
502.3 level agreement and paid to the Office of
502.4 Enterprise Technology.

502.5 **TANF Appropriations.** (1) $1,156,000 of
502.6 the TANF funds is appropriated each year of
502.7 the biennium to the commissioner for family
502.8 planning grants under Minnesota Statutes,
502.9 section 145.925.

502.10 (2) $3,579,000 of the TANF funds is
502.11 appropriated each year of the biennium to
502.12 the commissioner for home visiting and
502.13 nutritional services listed under Minnesota
502.14 Statutes, section 145.882, subdivision 7,
502.15 clauses (6) and (7). Funds must be distributed
502.16 to community health boards according to
502.17 Minnesota Statutes, section 145A.131,
502.18 subdivision 1.

502.19 (3) $2,000,000 of the TANF funds is
502.20 appropriated each year of the biennium to
502.21 the commissioner for decreasing racial and
502.22 ethnic disparities in infant mortality rates
502.23 under Minnesota Statutes, section 145.928,
502.24 subdivision 7.

502.25 (4) $4,978,000 of the TANF funds is
502.26 appropriated each year of the biennium to the
502.27 commissioner for the family home visiting
502.28 grant program according to Minnesota
502.29 Statutes, section 145A.17. $4,000,000 of the
502.30 funding must be distributed to community
502.31 health boards according to Minnesota
502.32 Statutes, section 145A.131, subdivision 1.
502.33 $978,000 of the funding must be distributed
502.34 to tribal governments based on Minnesota
502.35 Statutes, section 145A.14, subdivision 2a.

503.1 (5) The commissioner may use up to 6.23
503.2 percent of the funds appropriated each fiscal
503.3 year to conduct the ongoing evaluations
503.4 required under Minnesota Statutes, section
503.5 145A.17, subdivision 7, and training and
503.6 technical assistance as required under
503.7 Minnesota Statutes, section 145A.17,
503.8 subdivisions 4 and 5.

503.9 **TANF Carryforward.** Any unexpended
503.10 balance of the TANF appropriation in the
503.11 first year of the biennium does not cancel but
503.12 is available for the second year.

503.13 Subd. 3. **Policy Quality and Compliance**

503.14 Appropriations by Fund

503.15	General	9,391,000	9,391,000
503.16 503.17	State Government Special Revenue	16,537,000	16,454,000
503.18	Health Care Access	9,523,000	8,923,000

503.19 **Base Level Adjustment.** The state
503.20 government special revenue fund base shall
503.21 be reduced by $2,000 in fiscal year 2017. The
503.22 health care access base shall be increased by
503.23 $600,000 in fiscal year 2015.

503.24 Subd. 4. **Health Protection**

503.25 Appropriations by Fund

503.26	General	9,449,000	9,449,000
503.27 503.28	State Government Special Revenue	32,633,000	32,636,000

503.29 **Infectious Disease Laboratory.** Of the
503.30 general fund appropriation, $200,000 in
503.31 fiscal year 2014 and $200,000 in fiscal year
503.32 2015 are appropriated to the commissioner
503.33 to monitor infectious disease trends and
503.34 investigate infectious disease outbreaks.

503.35 **Surveillance for Elevated Blood Lead**
503.36 **Levels.** Of the general fund appropriation,

504.1 $100,000 in fiscal year 2014 and $100,000
504.2 in fiscal year 2015 are appropriated to the
504.3 commissioner for the blood lead surveillance
504.4 system under Minnesota Statutes, section
504.5 144.9502.

504.6 **Base Level Adjustment.** The state
504.7 government special revenue base is increased
504.8 by $6,000 in fiscal year 2016 and by $27,000
504.9 in fiscal year 2017.

504.10 Subd. 5. **Administrative Support Services**	7,772,000	7,772,000

504.11 **Regional Support for Local Public Health**
504.12 **Departments.** $350,000 in fiscal year
504.13 2014 and $350,000 in fiscal year 2015
504.14 are appropriated to the commissioner for
504.15 regional staff who provide specialized
504.16 expertise to local public health departments.

504.17 Sec. 5. **HEALTH-RELATED BOARDS**

504.18 Subdivision 1. **Total Appropriation**	**$ 16,728,000**	**$ 16,678,000**

504.19 This appropriation is from the state
504.20 government special revenue fund. The
504.21 amounts that may be spent for each purpose
504.22 are specified in the following subdivisions.

504.23 Subd. 2.**Board of Chiropractic Examiners**	470,000	470,000
504.24 Subd. 3. **Board of Dentistry**	1,820,000	1,820,000

504.25 **Health Professional Services Program.** Of
504.26 this appropriation, $704,000 in fiscal year
504.27 2014 and $704,000 in fiscal year 2015 from
504.28 the state government special revenue fund are
504.29 for the health professional services program.

504.30 Subd. 4. **Board of Dietetic and Nutrition** 504.31 **Practice**	111,000	111,000
504.32 Subd. 5. **Board of Marriage and Family** 504.33 **Therapy**	168,000	168,000

505.1 Subd. 6. **Board of Medical Practice** 3,867,000 3,867,000

505.2 Subd. 7. **Board of Nursing** 3,637,000 3,637,000

505.3 Subd. 8. **Board of Nursing Home**
505.4 **Administrators** 1,235,000 1,185,000

505.5 **Administrative Services Unit - Operating**
505.6 **Costs.** Of this appropriation, $676,000
505.7 in fiscal year 2014 and $626,000 in
505.8 fiscal year 2015 are for operating costs
505.9 of the administrative services unit. The
505.10 administrative services unit may receive
505.11 and expend reimbursements for services
505.12 performed by other agencies.

505.13 **Administrative Services Unit - Volunteer**
505.14 **Health Care Provider Program.** Of this
505.15 appropriation, $150,000 in fiscal year 2014
505.16 and $150,000 in fiscal year 2015 are to pay
505.17 for medical professional liability coverage
505.18 required under Minnesota Statutes, section
505.19 214.40.

505.20 **Administrative Services Unit - Contested**
505.21 **Cases and Other Legal Proceedings.** Of
505.22 this appropriation, $200,000 in fiscal year
505.23 2014 and $200,000 in fiscal year 2015 are
505.24 for costs of contested case hearings and other
505.25 unanticipated costs of legal proceedings
505.26 involving health-related boards funded
505.27 under this section. Upon certification of a
505.28 health-related board to the administrative
505.29 services unit that the costs will be incurred
505.30 and that there is insufficient money available
505.31 to pay for the costs out of money currently
505.32 available to that board, the administrative
505.33 services unit is authorized to transfer money
505.34 from this appropriation to the board for
505.35 payment of those costs with the approval

506.1 of the commissioner of management and
506.2 budget. This appropriation does not cancel.
506.3 Any unencumbered and unspent balances
506.4 remain available for these expenditures in
506.5 subsequent fiscal years.

506.6	Subd. 9. **Board of Optometry**	107,000	107,000
506.7	Subd. 10. **Board of Pharmacy**	2,345,000	2,345,000

506.8 **Prescription Electronic Reporting.** Of
506.9 this appropriation, $356,000 in fiscal year
506.10 2014 and $356,000 in fiscal year 2015 from
506.11 the state government special revenue fund
506.12 are to the board to operate the prescription
506.13 electronic reporting system in Minnesota
506.14 Statutes, section 152.126.

506.15	Subd. 11. **Board of Physical Therapy**	346,000	346,000
506.16	Subd. 12. **Board of Podiatry**	76,000	76,000
506.17	Subd. 13. **Board of Psychology**	847,000	847,000
506.18	Subd. 14. **Board of Social Work**	1,054,000	1,054,000
506.19	Subd. 15. **Board of Veterinary Medicine**	230,000	230,000
506.20 506.21	Subd. 16. **Board of Behavioral Health and Therapy**	415,000	415,000

506.22 506.23	Sec. 6. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$ 2,741,000**	**$ 2,741,000**

506.24 **Regional Grants.** $585,000 in fiscal year
506.25 2014 and $585,000 in fiscal year 2015 are
506.26 for regional emergency medical services
506.27 programs, to be distributed equally to the
506.28 eight emergency medical service regions.

506.29 **Cooper/Sams Volunteer Ambulance**
506.30 **Program.** $700,000 in fiscal year 2014 and
506.31 $700,000 in fiscal year 2015 are for the
506.32 Cooper/Sams volunteer ambulance program
506.33 under Minnesota Statutes, section 144E.40.

507.1 (a) Of this amount, $611,000 in fiscal year
507.2 2014 and $611,000 in fiscal year 2015
507.3 are for the ambulance service personnel
507.4 longevity award and incentive program under
507.5 Minnesota Statutes, section 144E.40.

507.6 (b) Of this amount, $89,000 in fiscal year
507.7 2014 and $89,000 in fiscal year 2015 are
507.8 for the operations of the ambulance service
507.9 personnel longevity award and incentive
507.10 program under Minnesota Statutes, section
507.11 144E.40.

507.12 **Ambulance Training Grant.** $361,000 in
507.13 fiscal year 2014 and $361,000 in fiscal year
507.14 2015 are for training grants.

507.15 **EMSRB Board Operations.** $1,095,000 in
507.16 fiscal year 2014 and $1,095,000 in fiscal year
507.17 2015 are for operations.

507.18 Sec. 7. **NURSING HOME** 507.19 **ADMINISTRATORS BOARD**	**$**	**10,000**	**$**	**10,000**
507.20 Sec. 8. **COUNCIL ON DISABILITY**	**$**	**614,000**	**$**	**614,000**
507.21 Sec. 9. **OMBUDSMAN FOR MENTAL** 507.22 **HEALTH AND DEVELOPMENTAL** 507.23 **DISABILITIES**	**$**	**1,654,000**	**$**	**1,654,000**
507.24 Sec. 10. **OMBUDSPERSON FOR FAMILIES**	**$**	**333,000**	**$**	**334,000**

507.25 Sec. 11. Minnesota Statutes 2012, section 256.01, subdivision 34, is amended to read:

507.26 Subd. 34. **Federal administrative reimbursement dedicated.** Federal
507.27 administrative reimbursement resulting from the following activities is appropriated to the
507.28 commissioner for the designated purposes:

507.29 (1) reimbursement for the Minnesota senior health options project; ~~and~~

507.30 (2) reimbursement related to prior authorization and inpatient admission certification
507.31 by a professional review organization. A portion of these funds must be used for activities
507.32 to decrease unnecessary pharmaceutical costs in medical assistance~~.~~; and

508.1 (3) reimbursement resulting from the federal child support grant expenditures
508.2 authorized under United States Code, title 42, section 1315.

508.3 Sec. 12. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
508.4 to read:

508.5 Subd. 35. **Federal reimbursement for privatized adoption grants.** Federal
508.6 reimbursement for privatized adoption grant and foster care recruitment grant expenditures
508.7 is appropriated to the commissioner for adoption grants and foster care and adoption
508.8 administrative purposes.

508.9 Sec. 13. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
508.10 to read:

508.11 Subd. 36. **DHS receipt center accounting.** The commissioner may transfer
508.12 appropriations to, and account for DHS receipt center operations in, the special revenue
508.13 fund.

508.14 Sec. 14. **TRANSFERS.**

508.15 Subdivision 1. **Grants.** The commissioner of human services, with the approval of
508.16 the commissioner of management and budget, may transfer unencumbered appropriation
508.17 balances for the biennium ending June 30, 2015, within fiscal years among the MFIP,
508.18 general assistance, general assistance medical care under Minnesota Statutes 2009
508.19 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP
508.20 child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental
508.21 aid, group residential housing programs, the entitlement portion of the chemical
508.22 dependency consolidated treatment fund, and between fiscal years of the biennium. The
508.23 commissioner shall inform the chairs and ranking minority members of the senate Health
508.24 and Human Services Finance Division and the house of representatives Health and Human
508.25 Services Finance Committee quarterly about transfers made under this provision.

508.26 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
508.27 money may be transferred within the Departments of Human Services and Health as the
508.28 commissioners consider necessary, with the advance approval of the commissioner of
508.29 management and budget. The commissioner shall inform the chairs and ranking minority
508.30 members of the senate Health and Human Services Finance Division and the house of
508.31 representatives Health and Human Services Finance Committee quarterly about transfers
508.32 made under this provision.

509.1 Sec. 15. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

509.2 The commissioners of health and human services shall not use indirect cost
509.3 allocations to pay for the operational costs of any program for which they are responsible.

509.4 Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

509.5 All uncodified language contained in this article expires on June 30, 2015, unless a
509.6 different expiration date is explicit.

509.7 Sec. 17. **EFFECTIVE DATE.**

509.8 This article is effective July 1, 2013, unless a different effective date is specified.

APPENDIX

Article locations in DD1233

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 37.23
ARTICLE 3	SAFE AND HEALTHY DEVELOPMENT OF CHILDREN	Page.Ln 104.18
ARTICLE 4	STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES	Page.Ln 184.7
ARTICLE 5	DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY	Page.Ln 195.31
ARTICLE 6	2013 MANAGED CARE ORGANIZATIONS RATE CONFORMITY	Page.Ln 214.9
ARTICLE 7	HEALTH CARE	Page.Ln 224.10
ARTICLE 8	CONTINUING CARE	Page.Ln 233.2
ARTICLE 9	WAIVER PROVIDER STANDARDS	Page.Ln 257.26
ARTICLE 10	WAIVER PROVIDER STANDARDS TECHNICAL CHANGES	Page.Ln 354.15
ARTICLE 11	MISCELLANEOUS	Page.Ln 372.7
ARTICLE 12	HOME CARE PROVIDERS	Page.Ln 381.11
ARTICLE 13	HEALTH DEPARTMENT	Page.Ln 441.13
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