1.1 .... moves to amend H.F. No. 1780 as follows:

1.2 Page 52, delete section 6 and insert:

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

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

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

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

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

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

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

1.18 (6) documentation of compliance with the background study requirements of section
1.19 144A.476 for all persons involved in the management, operation, or control of the home
1.20 care provider;

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

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

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

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

2.1 (11) documentation that identifies the managerial official who is in charge of
2.2 day-to-day operations and attestation that the person has reviewed and understands the
2.3 home care provider regulations;
2.4 (12) documentation that the applicant has designated one or more owners,
2.5 managerial officials, or employees as an agent or agents, which shall not affect the legal
2.6 responsibility of any other owner or managerial official under this chapter;
2.7 (13) the signature of the officer or managing agent on behalf of an entity, corporation,
2.8 association, or unit of government;
2.9 (14) verification that the applicant has the following policies and procedures in place
2.10 so that if a license is issued, the applicant will implement the policies and procedures
2.11 and keep them current:
2.12 (i) requirements in sections 626.556, reporting of maltreatment of minors, and
2.13 626.557, reporting of maltreatment of vulnerable adults;
2.14 (ii) conducting and handling background studies on employees;
2.15 (iii) orientation, training, and competency evaluations of home care staff, and a
2.16 process for evaluating staff performance;
2.17 (iv) handling complaints from clients, family members, or client representatives
2.18 regarding staff or services provided by staff;
2.19 (v) conducting initial evaluation of clients' needs and the providers' ability to provide
2.20 those services;
2.21 (vi) conducting initial and ongoing client evaluations and assessments and how
2.22 changes in a client's condition are identified, managed, and communicated to staff and
2.23 other health care providers as appropriate;
2.24 (vii) orientation to and implementation of the home care client bill of rights;
2.25 (viii) infection control practices;
2.26 (ix) reminders for medications, treatments, or exercises, if provided; and
2.27 (x) conducting appropriate screenings, or documentation of prior screenings, to
2.28 show that staff are free of tuberculosis, consistent with current United States Centers for
2.29 Disease Control standards; and
2.30 (15) other information required by the department.
2.31 Subd. 2. **Comprehensive home care license applications.** In addition to the
2.32 information and fee required in subdivision 1, applicants applying for a comprehensive
2.33 home care license must also provide verification that the applicant has the following
2.34 policies and procedures in place so that if a license is issued, the applicant will implement
2.35 the policies and procedures in this subdivision and keep them current:

3.1 (1) conducting initial and ongoing assessments of the client's needs by a registered
3.2 nurse or appropriate licensed health professional, including how changes in the client's
3.3 conditions are identified, managed, and communicated to staff and other health care
3.4 providers, as appropriate;
3.5 (2) ensuring that nurses and licensed health professionals have current and valid
3.6 licenses to practice;
3.7 (3) medication and treatment management;
3.8 (4) delegation of home care tasks by registered nurses or licensed health professionals;
3.9 (5) supervision of registered nurses and licensed health professionals; and
3.10 (6) supervision of unlicensed personnel performing delegated home care tasks.
3.11 Subd. 3. **License renewal.** (a) Except as provided in section 144A.475, a license
3.12 may be renewed for a period of one year if the licensee satisfies the following:
3.13 (1) submits an application for renewal in the format provided by the commissioner
3.14 at least 30 days before expiration of the license;
3.15 (2) submits the renewal fee in the amount specified in subdivision 7;
3.16 (3) has provided home care services within the past 12 months;
3.17 (4) complies with sections 144A.43 to 144A.4799;
3.18 (5) provides information sufficient to show that the applicant meets the requirements
3.19 of licensure, including items required under subdivision 1;
3.20 (6) provides verification that all policies under subdivision 1, are current; and
3.21 (7) provides any other information deemed necessary by the commissioner.
3.22 (b) A renewal applicant who holds a comprehensive home care license must also
3.23 provide verification that policies listed under subdivision 2 are current.
3.24 Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately
3.25 licensed if the commissioner determines that the units cannot adequately share supervision
3.26 and administration of services from the main office.
3.27 Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license
3.28 issued by the commissioner may not be transferred to another party. Before acquiring
3.29 ownership of a home care provider business, a prospective applicant must apply for a
3.30 new temporary license. A change of ownership is a transfer of operational control to
3.31 a different business entity, and includes:
3.32 (1) transfer of the business to a different or new corporation;
3.33 (2) in the case of a partnership, the dissolution or termination of the partnership under
3.34 chapter 323A, with the business continuing by a successor partnership or other entity;
3.35 (3) relinquishment of control of the provider to another party, including to a contract
3.36 management firm that is not under the control of the owner of the business' assets;

4.1 (4) transfer of the business by a sole proprietor to another party or entity; or
4.2 (5) in the case of a privately held corporation, the change in ownership or control of
4.3 50 percent or more of the outstanding voting stock.
4.4 Subd. 6. **Notification of changes of information.** The temporary licensee or
4.5 licensee shall notify the commissioner in writing within ten working days after any
4.6 change in the information required in subdivision 1, except the information required in
4.7 subdivision 1, clause (5), is required at the time of license renewal.
4.8 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial
4.9 applicant seeking a temporary home care licensure must submit the following application
4.10 fee to the commissioner along with a completed application:
4.11 (1) basic home care provider, $2,100; or
4.12 (2) comprehensive home care provider, $4,200.
4.13 (b) A home care provider who is filing a change of ownership as required under
4.14 subdivision 5 must submit the following application fee to the commissioner, along with
4.15 the documentation required for the change of ownership:
4.16 (1) basic home care provider, $2,100; or
4.17 (2) comprehensive home care provider, $4,200.
4.18 (c) A home care provider who is seeking to renew the provider's license shall pay a
4.19 fee to the commissioner based on revenues derived from the provision of home care
4.20 services during the calendar year prior to the year in which the application is submitted,
4.21 according to the following schedule:
4.22 **License Renewal Fee**

	Provider Annual Revenue	Fee
4.23	**Provider Annual Revenue**	**Fee**
4.24	greater than $1,500,000	$6,625
4.25 4.26	greater than $1,275,000 and no more than $1,500,000	$5,797
4.27 4.28	greater than $1,100,000 and no more than $1,275,000	$4,969
4.29 4.30	greater than $950,000 and no more than $1,100,000	$4,141
4.31 4.32	greater than $850,000 and no more than $950,000	$3,727
4.33 4.34	greater than $750,000 and no more than $850,000	$3,313
4.35 4.36	greater than $650,000 and no more than $750,000	$2,898
4.37 4.38	greater than $550,000 and no more than $650,000	$2,485
4.39 4.40	greater than $450,000 and no more than $550,000	$2,070

greater than $350,000 and no more than $450,000	$1,656
greater than $250,000 and no more than $350,000	$1,242
greater than $100,000 and no more than $250,000	$828
greater than $50,000 and no more than $100,000	$500
greater than $25,000 and no more than $50,000	$400
no more than $25,000	$200

(d) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(e) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(f) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

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

(h) The license renewal fee schedule in this subdivision is effective July 1, 2016."

Page 58, delete section 8 and insert:

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

Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home care provider. By June 30, 2016, the commissioner shall conduct a survey of home care providers on a frequency of at least once every three years. Survey frequency may be based on the license level, the provider's compliance history, number of clients served, or other factors as determined by the department deemed necessary to ensure the health, safety, and welfare of clients and compliance with the law.

Subd. 2. **Types of home care surveys.** (a) "Initial full survey" is the survey conducted of a new temporary licensee after the department is notified or has evidence that the licensee is providing home care services to determine if the provider is in compliance with home care requirements. Initial surveys must be completed within 14 months after the department's issuance of a temporary basic or comprehensive license.

(b) "Core survey" means periodic inspection of home care providers to determine ongoing compliance with the home care requirements, focusing on the essential health and

6.1 safety requirements. Core surveys are available to licensed home care providers who have
6.2 been licensed for three years and surveyed at least once in the past three years with the
6.3 latest survey having no widespread violations beyond Level 1 as provided in subdivision
6.4 11. Providers must also not have had any substantiated licensing complaints, substantiated
6.5 complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors
6.6 Act, or an enforcement action as authorized in section 144A.475 in the past three years.

6.7 (1) The core survey for basic license-level providers reviews compliance in the
6.8 following areas:

6.9 (i) reporting of maltreatment;

6.10 (ii) orientation to and implementation of Home Care Client Bill of Rights;

6.11 (iii) statement of home care services;

6.12 (iv) initial evaluation of clients and initiation of services;

6.13 (v) basic-license level client review and monitoring;

6.14 (vi) service plan implementation and changes to the service plan;

6.15 (vii) client complaint and investigative process;

6.16 (viii) competency of unlicensed personnel; and

6.17 (ix) infection control.

6.18 (2) For comprehensive license-level providers, the core survey will include
6.19 everything in the basic license-level core survey plus these areas:

6.20 (i) delegation to unlicensed personnel;

6.21 (ii) assessment, monitoring, and reassessment of clients; and

6.22 (iii) medication, treatment, and therapy management.

6.23 (c) "Full survey" means the periodic inspection of home care providers to determine
6.24 ongoing compliance with the home care requirements that cover the core survey areas
6.25 and all the legal requirements for home care providers. A full survey is conducted for all
6.26 temporary licensees and for providers who do not meet the requirements needed for a core
6.27 survey, and when a surveyor identifies unacceptable client health or safety risks during a
6.28 core survey. A full survey will include all the tasks identified as part of the core survey
6.29 and any additional review deemed necessary by the department, including additional
6.30 observation, interviewing, or records review of additional clients and staff.

6.31 (d) "Follow-up surveys" are conducted to determine if a home care provider has
6.32 corrected deficient issues and systems identified during a core survey, full survey, or
6.33 complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax,
6.34 mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be
6.35 concluded with an exit conference and written information provided on the process for
6.36 requesting a reconsideration of the survey results.

7.1 (e) Upon receiving information that a home care provider has violated or is currently
7.2 violating a requirement of sections 144A.43 to 144A.482, the commissioner shall
7.3 investigate the complaint according to sections 144A.51 to 144A.54.

7.4 Subd. 3. **Survey process.** (a) The survey process for core surveys shall include the
7.5 following as applicable to the particular licensee and setting surveyed:

7.6 (1) presurvey review of pertinent documents and notification to the ombudsman
7.7 for long-term care;

7.8 (2) an entrance conference with available staff;

7.9 (3) communication with managerial officials or the registered nurse in charge, if
7.10 available, and ongoing communication with key staff throughout the survey regarding
7.11 information needed by the surveyor, clarifications regarding home care requirements, and
7.12 applicable standards of practice;

7.13 (4) presentation of written contact information to the provider about the survey staff
7.14 conducting the survey, the supervisor, and the process for requesting a reconsideration of
7.15 the survey results;

7.16 (5) a brief tour of a sample of the housing with services establishments in which the
7.17 provider is providing home care services;

7.18 (6) a sample selection of home care clients;

7.19 (7) information-gathering through client and staff observations, client and staff
7.20 interviews, and reviews of records, policies, procedures, practices, and other agency
7.21 information;

7.22 (8) interviews of clients' family members, if available, with clients' consent when the
7.23 client can legally give consent;

7.24 (9) except for complaint surveys conducted by the Office of Health Facilities
7.25 Complaints, exit conference, with preliminary findings shared and discussed with the
7.26 provider and written information provided on the process for requesting a reconsideration
7.27 of the survey results; and

7.28 (10) postsurvey analysis of findings and formulation of survey results, including
7.29 correction orders when applicable.

7.30 Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted
7.31 without advance notice to home care providers. Surveyors may contact the home care
7.32 provider on the day of a survey to arrange for someone to be available at the survey site.
7.33 The contact does not constitute advance notice.

7.34 Subd. 5. **Information provided by home care provider.** The home care provider
7.35 shall provide accurate and truthful information to the department during a survey,
7.36 investigation, or other licensing activities.

8.1 Subd. 6. **Providing client records.** Upon request of a surveyor, home care providers
8.2 shall provide a list of current and past clients or client representatives that includes
8.3 addresses and telephone numbers and any other information requested about the services
8.4 to clients within a reasonable period of time.

8.5 Subd. 7. **Contacting and visiting clients.** Surveyors may contact or visit a home
8.6 care provider's clients to gather information without notice to the home care provider.
8.7 Before visiting a client, a surveyor shall obtain the client's or client's representative's
8.8 permission by telephone, mail, or in person. Surveyors shall inform all clients or client's
8.9 representatives of their right to decline permission for a visit.

8.10 Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the
8.11 commissioner finds upon survey or during a complaint investigation that a home care
8.12 provider, a managerial official, or an employee of the provider is not in compliance with
8.13 sections 144A.43 to 144A.482. The correction order shall cite the specific statute and
8.14 document areas of noncompliance and the time allowed for correction.

8.15 (b) The commissioner shall mail copies of any correction order within 30 calendar
8.16 days after exit survey to the last known address of the home care provider. A copy of each
8.17 correction order and copies of any documentation supplied to the commissioner shall be
8.18 kept on file by the home care provider, and public documents shall be made available for
8.19 viewing by any person upon request. Copies may be kept electronically.

8.20 (c) By the correction order date, the home care provider must document in the
8.21 provider's records any action taken to comply with the correction order. The commissioner
8.22 may request a copy of this documentation and the home care provider's action to respond
8.23 to the correction order in future surveys, upon a complaint investigation, and as otherwise
8.24 needed.

8.25 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations
8.26 or any violations determined to be widespread, the department shall conduct a follow-up
8.27 survey within 90 calendar days of the survey. When conducting a follow-up survey, the
8.28 surveyor will focus on whether the previous violations have been corrected and may also
8.29 address any new violations that are observed while evaluating the corrections that have
8.30 been made. If a new violation is identified on a follow-up survey, no fine will be imposed
8.31 unless it is not corrected on the next follow-up survey.

8.32 Subd. 10. **Performance incentive.** A licensee is eligible for a performance
8.33 incentive if there are no violations identified in a core or full survey. The performance
8.34 incentive is a ten percent discount on the licensee's next home care renewal license fee.

8.35 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be
8.36 assessed based on the level and scope of the violations described in paragraph (c) as follows:

9.1 (1) Level 1, no fines or enforcement;
9.2 (2) Level 2, fines ranging from $0 to $500, in addition to any of the enforcement
9.3 mechanisms authorized in section 144A.475 for widespread violations;
9.4 (3) Level 3, fines ranging from $500 to $1,000, in addition to any of the enforcement
9.5 mechanisms authorized in section 144A.475; and
9.6 (4) Level 4, fines ranging from $1,000 to $5,000, in addition to any of the
9.7 enforcement mechanisms authorized in section 144A.475.
9.8 (b) Correction orders for violations are categorized by both level and scope as
9.9 follows and fines will be assessed accordingly:
9.10 (1) Level of violation:
9.11 (i) Level 1. A violation that has no potential to cause more than a minimal impact on
9.12 the client and does not affect health or safety.
9.13 (ii) Level 2. A violation that did not harm the client's health or safety, but had the
9.14 potential to have harmed a client's health or safety, but was not likely to cause serious
9.15 injury, impairment, or death.
9.16 (iii) Level 3. A violation that harmed a client's health or safety, not including serious
9.17 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
9.18 impairment, or death.
9.19 (iv) Level 4. A violation that results in serious injury, impairment, or death.
9.20 (2) Scope of violation:
9.21 (i) Isolated. When one or a limited number of clients are affected, or one or a limited
9.22 number of staff are involved, or the situation has occurred only occasionally.
9.23 (ii) Pattern. When more than a limited number of clients are affected, more than
9.24 a limited number of staff are involved, or the situation has occurred repeatedly but is
9.25 not found to be pervasive.
9.26 (iii) Widespread. When problems are pervasive or represent a systemic failure that
9.27 has affected or has the potential to affect a large portion or all of the clients.
9.28 (c) If the commissioner finds that the applicant or a home care provider required
9.29 to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the
9.30 date specified in the correction order or conditional license resulting from a survey or
9.31 complaint investigation, the commissioner may impose a fine. A notice of noncompliance
9.32 with a correction order must be mailed to the applicant's or provider's last known address.
9.33 The noncompliance notice must list the violations not corrected.
9.34 (d) The license holder must pay the fines assessed on or before the payment date
9.35 specified. If the license holder fails to fully comply with the order, the commissioner
9.36 may issue a second fine or suspend the license until the license holder complies by

10.1 paying the fine. A timely appeal shall stay payment of the fine until the commissioner
10.2 issues a final order.
10.3 (e) A license holder shall promptly notify the commissioner in writing when a
10.4 violation specified in the order is corrected. If upon reinspection the commissioner
10.5 determines that a violation has not been corrected as indicated by the order, the
10.6 commissioner may issue a second fine. The commissioner shall notify the license holder by
10.7 mail to the last known address in the licensing record that a second fine has been assessed.
10.8 The license holder may appeal the second fine as provided under this subdivision.
10.9 (f) A home care provider that has been assessed a fine under this subdivision has a
10.10 right to a reconsideration or a hearing under this section and chapter 14.
10.11 (g) When a fine has been assessed, the license holder may not avoid payment by
10.12 closing, selling, or otherwise transferring the licensed program to a third party. In such an
10.13 event, the license holder shall be liable for payment of the fine.
10.14 (h) In addition to any fine imposed under this section, the commissioner may assess
10.15 costs related to an investigation that results in a final order assessing a fine or other
10.16 enforcement action authorized by this chapter.
10.17 (i) Fines collected under this subdivision shall be deposited in the state government
10.18 special revenue fund and credited to an account separate from the revenue collected under
10.19 section 144A.472. Subject to an appropriation by the legislature, the revenue from the
10.20 fines collected may be used by the commissioner for special projects to improve home care
10.21 in Minnesota as recommended by the advisory council established in section 144A.4799.
10.22 Subd. 12. **Reconsideration.** The commissioner shall make available to home
10.23 care providers a correction order reconsideration process. This process may be used
10.24 to challenge the correction order issued, including the level and scope described in
10.25 subdivision 9, and any fine assessed. During the correction order reconsideration request,
10.26 the issuance for the correction orders under reconsideration are not stayed, but the
10.27 department will post in formation on the Web site with the correction order that the
10.28 licensee has requested a reconsideration required and that the review is pending.
10.29 (a) A licensed home care provider may request from the commissioner, in writing,
10.30 a correction order reconsideration regarding any correction order issued to the provider.
10.31 The correction order reconsideration shall not be reviewed by any surveyor, investigator,
10.32 or supervisor that participated in the writing or reviewing of the correction order being
10.33 disputed. The correction order reconsiderations may be conducted in person by telephone,
10.34 by another electronic form, or in writing, as determined by the commissioner. The
10.35 commissioner shall respond in writing to the request from a home care provider for
10.36 a correction order reconsideration within 60 days of the date the provider requests a

11.1 reconsideration. The commissioner's response shall identify the commissioner's decision
11.2 regarding each citation challenged by the home care provider.
11.3 The findings of a correction order reconsideration process shall be one or more of
11.4 the following:
11.5 (1) Supported in full. The correction order is supported in full, with no deletion of
11.6 findings to the citation.
11.7 (2) Supported in substance. The correction order is supported, but one or more
11.8 findings are deleted or modified without any change in the citation.
11.9 (3) Correction order cited an incorrect home care licensing requirement. The
11.10 correction order is amended by changing the correction order to the appropriate statutory
11.11 reference.
11.12 (4) Correction order was issued under an incorrect citation. The correction order is
11.13 amended to be issued under the more appropriate correction order citation.
11.14 (5) The correction order is rescinded.
11.15 (6) Fine is amended. It is determined the fine assigned to the correction order was
11.16 applied incorrectly.
11.17 (7) The level or scope of the citation is modified based on the reconsideration.
11.18 (b) If the correction order findings are changed by the commissioner, the
11.19 commissioner shall update the correction order Web site accordingly.
11.20 Subd. 13. **Home care surveyor training.** Before conducting a home care survey,
11.21 each home care surveyor must receive training on the following topics:
11.22 (1) Minnesota home care licensure requirements;
11.23 (2) Minnesota Home Care Client Bill of Rights;
11.24 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;
11.25 (4) principles of documentation;
11.26 (5) survey protocol and processes;
11.27 (6) Offices of the Ombudsman roles;
11.28 (7) Office of Health Facility Complaints;
11.29 (8) Minnesota landlord-tenant and housing with services laws;
11.30 (9) types of payors for home care services; and
11.31 (10) Minnesota Nurse Practice Act for nurse surveyors.
11.32 Materials used for this training will be posted on the department Web site. Requisite
11.33 understanding of these topics will be reviewed as part of the quality improvement plan
11.34 in section 28."
11.35 Page 76, delete section 15 and insert:

11.36 "Sec. ... **[144A.4792] MEDICATION MANAGEMENT.**

12.1 Subdivision 1. **Medication management services; comprehensive home care**
12.2 **license.** (a) This subdivision applies only to home care providers with a comprehensive
12.3 home care license that provides medication management services to clients. Medication
12.4 management services may not be provided by a home care provider that has a basic
12.5 home care license.

12.6 (b) A comprehensive home care provider who provides medication management
12.7 services must develop, implement, and maintain current written medication management
12.8 policies and procedures. The policies and procedures must be developed under the
12.9 supervision and direction of a registered nurse, licensed health professional, or pharmacist
12.10 consistent with current practice standards and guidelines.

12.11 (c) The written policies and procedures must address requesting and receiving
12.12 prescriptions for medications; preparing and giving medications; verifying that
12.13 prescription drugs are administered as prescribed; documenting medication management
12.14 activities; controlling and storing medications; monitoring and evaluating medication use;
12.15 resolving medication errors; communicating with the prescriber, pharmacist, and client
12.16 and client representative, if any; disposing of unused medications; and educating clients
12.17 and client representatives about medications. When controlled substances are being
12.18 managed, the policies and procedures must also identify how the provider will ensure
12.19 security and accountability for the overall management, control, and disposition of those
12.20 substances in compliance with state and federal regulations and with subdivision 22.

12.21 Subd. 2. **Provision of medication management services.** (a) For each client who
12.22 requests medication management services, the comprehensive home care provider shall,
12.23 prior to providing medication management services, have a registered nurse, licensed
12.24 health professional, or authorized prescriber under section 151.37 conduct an assessment
12.25 to determine what mediation management services will be provided and how the services
12.26 will be provided. This assessment must be conducted face-to-face with the client. The
12.27 assessment must include an identification and review of all medications the client is known
12.28 to be taking. The review and identification must include indications for medications, side
12.29 effects, contraindications, allergic or adverse reactions, and actions to address these issues.

12.30 (b) The assessment must identify interventions needed in management of
12.31 medications to prevent diversion of medication by the client or others who may have
12.32 access to the medications. Diversion of medications means the misuse, theft, or illegal
12.33 or improper disposition of medications.

12.34 Subd. 3. **Individualized medication monitoring and reassessment.** The
12.35 comprehensive home care provider must monitor and reassess the client's medication

13.1 management services as needed under subdivision 14 when the client presents with
13.2 symptoms or other issues that may be medication-related and, at a minimum, annually.
13.3 Subd. 4. **Client refusal.** The home care provider must document in the client's
13.4 record any refusal for an assessment for medication management by the client. The
13.5 provider must discuss with the client the possible consequences of the client's refusal and
13.6 document the discussion in the client's record.
13.7 Subd. 5. **Individualized medication management plan.** (a) For each client
13.8 receiving medication management services, the comprehensive home care provider must
13.9 prepare and include in the service plan a written statement of the medication management
13.10 services that will be provided to the client. The provider must develop and maintain a
13.11 current individualized medication management record for each client based on the client's
13.12 assessment that must contain the following:
13.13 (1) a statement describing the medication management services that will be provided;
13.14 (2) a description of storage of medications based on the client's needs and
13.15 preferences, risk of diversion, and consistent with the manufacturer's directions;
13.16 (3) documentation of specific client instructions relating to the administration
13.17 of medications;
13.18 (4) identification of persons responsible for monitoring medication supplies and
13.19 ensuring that medication refills are ordered on a timely basis;
13.20 (5) identification of medication management tasks that may be delegated to
13.21 unlicensed personnel;
13.22 (6) procedures for staff notifying a registered nurse or appropriate licensed health
13.23 professional when a problem arises with medication management services; and
13.24 (7) any client-specific requirements relating to documenting medication
13.25 administration, verifications that all medications are administered as prescribed, and
13.26 monitoring of medication use to prevent possible complications or adverse reactions.
13.27 (b) The medication management record must be current and updated when there are
13.28 any changes.
13.29 Subd. 6. **Administration of medication.** Medications may be administered by a
13.30 nurse, physician, or other licensed health practitioner authorized to administer medications
13.31 or by unlicensed personnel who have been delegated medication administration tasks by
13.32 a registered nurse.
13.33 Subd. 7. **Delegation of medication administration.** When administration of
13.34 medications is delegated to unlicensed personnel, the comprehensive home care provider
13.35 must ensure that the registered nurse has:

14.1 (1) instructed the unlicensed personnel in the proper methods to administer the
14.2 medications, and the unlicensed personnel has demonstrated ability to competently follow
14.3 the procedures;
14.4 (2) specified, in writing, specific instructions for each client and documented those
14.5 instructions in the client's records; and
14.6 (3) communicated with the unlicensed personnel about the individual needs of
14.7 the client.
14.8 Subd. 8. **Documentation of administration of medications.** Each medication
14.9 administered by comprehensive home care provider staff must be documented in the
14.10 client's record. The documentation must include the signature and title of the person
14.11 who administered the medication. The documentation must include the medication
14.12 name, dosage, date and time administered, and method and route of administration. The
14.13 staff must document the reason why medication administration was not completed as
14.14 prescribed and document any follow-up procedures that were provided to meet the client's
14.15 needs when medication was not administered as prescribed and in compliance with the
14.16 client's medication management plan.
14.17 Subd. 9. **Documentation of medication set up.** Documentation of dates of
14.18 medication set up, name of medication, quantity of dose, times to be administered, route
14.19 of administration, and name of person completing medication set up must be done at
14.20 time of set up.
14.21 Subd. 10. **Medications management for clients who will be away from home.** (a)
14.22 A home care provider that is providing medication management services to the client and
14.23 controls the client's access to the medications must develop and implement policies and
14.24 procedures for giving accurate and current medications to clients for planned or unplanned
14.25 times away from home according to the client's individualized medication management
14.26 plan. The policy and procedures must state that:
14.27 (1) for planned time away, the medications must be obtained from the pharmacy or
14.28 set up by the registered nurse according to appropriate state and federal laws and nursing
14.29 standards of practice;
14.30 (2) for unplanned time away, when the pharmacy is not able to provide the
14.31 medications, a licensed nurse or unlicensed personnel shall give the client or client's
14.32 representative medications in amounts and dosages needed for the length of the anticipated
14.33 absence, not to exceed 120 hours;
14.34 (3) the client, or the client's representative, must be provided written information
14.35 on medications, including any special instructions for administering or handling the
14.36 medications, including controlled substances;

15.1 (4) the medications must be placed in a medication container or containers
15.2 appropriate to the provider's medication system and must be labeled with the client's name
15.3 and the dates and times that the medications are scheduled; and
15.4 (5) the client or client's representative must be provided in writing the home care
15.5 provider's name and information on how to contact the home care provider.
15.6 (b) For unplanned time away when the licensed nurse is not available, the registered
15.7 nurse may delegate this task to unlicensed personnel if:
15.8 (1) the registered nurse has trained the unlicensed staff and determined the
15.9 unlicensed staff is competent to follow the procedures for giving medications to clients;
15.10 (2) the registered nurse has developed written procedures for the unlicensed
15.11 personnel, including any special instructions or procedures regarding controlled substances
15.12 that are prescribed for the client. The procedures must address:
15.13 (i) the type of container or containers to be used for the medications appropriate to
15.14 the provider's medication system;
15.15 (ii) how the container or containers must be labeled;
15.16 (iii) the written information about the medications to be given to the client or client's
15.17 representative;
15.18 (iv) how the unlicensed staff will document in the client's record that medications
15.19 have been given to the client or the client's representative, including documenting the date
15.20 the medications were given to the client or the client's representative and who received the
15.21 medications, the person who gave the medications to the client, the number of medications
15.22 that were given to the client, and other required information;
15.23 (v) how the registered nurse will be notified that medications have been given to
15.24 the client or client's representative and whether the registered nurse needs to be contacted
15.25 before the medications are given to the client or the client's representative; and
15.26 (vi) a review by the registered nurse of the completion of this task to verify that this
15.27 task was completed accurately by the unlicensed personnel.
15.28 Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home
15.29 care provider must determine whether it will require a prescription for all medications it
15.30 manages. The comprehensive home care provider must inform the client or the client's
15.31 representative whether the comprehensive home care provider requires a prescription
15.32 for all over-the-counter and dietary supplements before the comprehensive home care
15.33 provider will agree to manage those medications.
15.34 Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.**
15.35 A comprehensive home care provider providing medication management services for
15.36 over-the-counter drugs or dietary supplements must retain those items in the original labeled

16.1 container with directions for use prior to setting up for immediate or later administration.
16.2 The provider must verify that the medications are up-to-date and stored as appropriate.

16.3 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
16.4 prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed
16.5 medications that the comprehensive home care provider is managing for the client.

16.6 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least
16.7 every 12 months or more frequently as indicated by the assessment in subdivision 2.
16.8 Prescriptions for controlled substances must comply with chapter 152.

16.9 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an
16.10 authorized prescriber must be received by a nurse or pharmacist. The order must be
16.11 handled according to Minnesota Rules, part 6800.6200.

16.12 Subd. 16. **Written or electronic prescription.** When a written or electronic
16.13 prescription is received, it must be communicated to the registered nurse in charge and
16.14 recorded or placed in the client's record.

16.15 Subd. 17. **Records confidential.** A prescription or order received verbally, in
16.16 writing, or electronically must be kept confidential according to sections 144.291 to
16.17 144.298 and 144A.44.

16.18 Subd. 18. **Medications provided by client or family members.** When the
16.19 comprehensive home care provider is aware of any medications or dietary supplements
16.20 that are being used by the client and are not included in the assessment for medication
16.21 management services, the staff must advise the registered nurse and document that in
16.22 the client's record.

16.23 Subd. 19. **Storage of drugs.** A comprehensive home care provider providing
16.24 storage of medications outside of the client's private living space must store all prescription
16.25 drugs in securely locked and substantially constructed compartments according to the
16.26 manufacturer's directions and permit only authorized personnel to have access.

16.27 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for
16.28 immediate or later administration, must be kept in the original container in which it was
16.29 dispensed by the pharmacy bearing the original prescription label with legible information
16.30 including the expiration or beyond-use date of a time-dated drug.

16.31 Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or
16.32 saved for use by anyone other than the client.

16.33 Subd. 22. **Disposition of drugs.** (a) Any current medications being managed by the
16.34 comprehensive home care provider must be given to the client or the client's representative
16.35 when the client's service plan ends or medication management services are no longer part
16.36 of the service plan. Medications that have been stored in the client's private living space

17.1 for a client that is deceased or that have been discontinued or that have expired may be
17.2 given to the client or the client's representative for disposal.
17.3 (b) The comprehensive home care provider will dispose of any medications
17.4 remaining with the comprehensive home care provider that are discontinued or expired or
17.5 upon the termination of the service contract or the client's death according to state and
17.6 federal regulations for disposition of drugs and controlled substances.
17.7 (c) Upon disposition, the comprehensive home care provider must document in the
17.8 client's record the disposition of the medications including the medication's name, strength,
17.9 prescription number as applicable, quantity, to whom the medications were given, date of
17.10 disposition, and names of staff and other individuals involved in the disposition.
17.11 Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing
17.12 medication management must develop and implement procedures for loss or spillage of all
17.13 controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must
17.14 require that when a spillage of a controlled substance occurs, a notation must be made
17.15 in the client's record explaining the spillage and the actions taken. The notation must
17.16 be signed by the person responsible for the spillage and include verification that any
17.17 contaminated substance was disposed of according to state or federal regulations.
17.18 (b) The procedures must require the comprehensive home care provider of
17.19 medication management to investigate any known loss or unaccounted for prescription
17.20 drugs and take appropriate action required under state or federal regulations and document
17.21 the investigation in required records."
17.22 Page 81, delete section 16 and insert:

17.23 "Sec. ... **[144A.4793] TREATMENT AND THERAPY MANAGEMENT**
17.24 **SERVICES.**
17.25 Subdivision 1. **Providers with a comprehensive home care license.** This section
17.26 applies only to home care providers with a comprehensive home care license that provide
17.27 treatment or therapy management services to clients. Treatment or therapy management
17.28 services cannot be provided by a home care provider that has a basic home care license.
17.29 Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who
17.30 provides treatment and therapy management services must develop, implement, and
17.31 maintain up-to-date written treatment or therapy management policies and procedures.
17.32 The policies and procedures must be developed under the supervision and direction of
17.33 a registered nurse or appropriate licensed health professional consistent with current
17.34 practice standards and guidelines.
17.35 (b) The written policies and procedures must address requesting and receiving
17.36 orders or prescriptions for treatments or therapies, providing the treatment or therapy,

18.1 documenting of treatment or therapy activities, educating and communicating with clients
18.2 about treatments or therapy they are receiving, monitoring and evaluating the treatment
18.3 and therapy, and communicating with the prescriber.

18.4 Subd. 3. **Individualized treatment or therapy management plan.** For each
18.5 client receiving management of ordered or prescribed treatments or therapy services, the
18.6 comprehensive home care provider must prepare and include in the service plan a written
18.7 statement of the treatment or therapy services that will be provided to the client. The
18.8 provider must also develop and maintain a current individualized treatment and therapy
18.9 management record for each client which must contain at least the following:

18.10 (1) a statement of the type of services that will be provided;

18.11 (2) documentation of specific client instructions relating to the treatments or therapy
18.12 administration;

18.13 (3) identification of treatment or therapy tasks that will be delegated to unlicensed
18.14 personnel;

18.15 (4) procedures for notifying a registered nurse or appropriate licensed health
18.16 professional when a problem arises with treatments or therapy services; and

18.17 (5) any client-specific requirements relating to documentation of treatment
18.18 and therapy received, verification that all treatment and therapy was administered as
18.19 prescribed, and monitoring of treatment or therapy to prevent possible complications or
18.20 adverse reactions. The treatment or therapy management record must be current and
18.21 updated when there are any changes.

18.22 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed
18.23 treatments or therapies must be administered by a nurse, physician, or other licensed health
18.24 professional authorized to perform the treatment or therapy, or may be delegated or assigned
18.25 to unlicensed personnel by the licensed health professional according to the appropriate
18.26 practice standards for delegation or assignment. When administration of a treatment or
18.27 therapy is delegated or assigned to unlicensed personnel, the home care provider must
18.28 ensure that the registered nurse or authorized licensed health professional has:

18.29 (1) instructed the unlicensed personnel in the proper methods with respect to each
18.30 client and has demonstrated their ability to competently follow the procedures;

18.31 (2) specified, in writing, specific instructions for each client and documented those
18.32 instructions in the client's record; and

18.33 (3) communicated with the unlicensed personnel about the individual needs of
18.34 the client.

18.35 Subd. 5. **Documentation of administration of treatments and therapies.** Each
18.36 treatment or therapy administered by a comprehensive home care provider must be

19.1 documented in the client's record. The documentation must include the signature and title
19.2 of the person who administered the treatment or therapy and must include the date and
19.3 time of administration. When treatment or therapies are not administered as ordered or
19.4 prescribed, the provider must document the reason why it was not administered and any
19.5 follow-up procedures that were provided to meet the client's needs.

19.6 Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or
19.7 electronically recorded order or prescription for all treatments and therapies. The order
19.8 must contain the name of the client, description of the treatment or therapy to be provided,
19.9 and the frequency and other information needed to administer the treatment or therapy."

19.10 Page 87, delete section 19 and insert:

19.11 "Sec. ... **[144A.4796] ORIENTATION AND ANNUAL TRAINING**
19.12 **REQUIREMENTS.**

19.13 Subdivision 1. **Orientation of staff and supervisors to home care.** All staff
19.14 providing and supervising direct home care services must complete an orientation to home
19.15 care licensing requirements and regulations before providing home care services to clients.
19.16 The orientation may be incorporated into the training required under subdivision 6. The
19.17 orientation need only be completed once for each staff person and is not transferable
19.18 to another home care provider.

19.19 Subd. 2. **Content.** The orientation must contain the following topics:

19.20 (1) an overview of sections 144A.43 to 144A.4798;

19.21 (2) introduction and review of all the provider's policies and procedures related to
19.22 the provision of home care services;

19.23 (3) handling of emergencies and use of emergency services;

19.24 (4) compliance with and reporting the maltreatment of minors or vulnerable adults
19.25 under sections 626.556 and 626.557;

19.26 (5) home care bill of rights, under section 144A.44;

19.27 (6) handling of clients' complaints; reporting of complaints and where to report
19.28 complaints including information on the Office of Health Facility Complaints and the
19.29 Common Entry Point;

19.30 (7) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
19.31 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
19.32 Ombudsman at the Department of Human Services, county managed care advocates,
19.33 or other relevant advocacy services; and

19.34 (8) review of the types of home care services the employee will be providing and
19.35 the provider's scope of licensure.

20.1 Subd. 3. **Verification and documentation of orientation.** Each home care provider
20.2 shall retain evidence in the employee record of each staff person having completed the
20.3 orientation required by this section.

20.4 Subd. 4. **Orientation to client.** Staff providing home care services must be oriented
20.5 specifically to each individual client and the services to be provided. This orientation may
20.6 be provided in person, orally, in writing, or electronically.

20.7 Subd. 5. **Training required relating to Alzheimer's disease and related disorders.**
20.8 For home care providers that provide services for persons with Alzheimer's or related
20.9 disorders, all direct care staff and supervisors working with those clients must receive
20.10 training that includes a current explanation of Alzheimer's disease and related disorders
20.11 effective approaches to use to problem solve when working with a client's challenging
20.12 behaviors, and how to communicate with clients who have Alzheimer's or related disorders.

20.13 Subd. 6. **Required annual training.** All staff that perform direct home care
20.14 services must complete at least eight hours of annual training for each 12 months of
20.15 employment. The training may be obtained from the home care provider or another source
20.16 and must include topics relevant to the provision of home care services. The annual
20.17 training must include:

20.18 (1) training on reporting of maltreatment of minors under section 626.556 and
20.19 maltreatment of vulnerable adults under section 626.557, whichever is applicable to the
20.20 services provided;

20.21 (2) review of the home care bill of rights in section 144A.44;

20.22 (3) review of infection control techniques used in the home and implementation of
20.23 infection control standards including a review of hand washing techniques; the need for
20.24 and use of protective gloves, gowns, and masks; appropriate disposal of contaminated
20.25 materials and equipment, such as dressings, needles, syringes, and razor blades;
20.26 disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of
20.27 communicable diseases; and

20.28 (4) review of the provider's policies and procedures relating to the provision of home
20.29 care services and how to implement those policies and procedures.

20.30 Subd. 7. **Documentation.** A home care provider must retain documentation in the
20.31 employee records of the staff that have satisfied the orientation and training requirements
20.32 of this section."

20.33 Page 92, delete sections 23 and 24 and insert:

20.34 "Sec. ... **[144A.481] HOME CARE LICENSING IMPLEMENTATION FOR**
20.35 **NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

21.1 Subdivision 1. **Temporary home care licenses and changes of ownership.** (a)
21.2 Beginning January 1, 2014, all temporary license applicants must apply for either a
21.3 temporary basic or comprehensive home care license.

21.4 (b) Temporary home care temporary licenses issued beginning January 1, 2014,
21.5 will be issued according to the provisions in sections 144A.43 to 144A.4799 and fees in
21.6 section 144A.472 and will be required to comply with this chapter.

21.7 (c) No temporary licenses or licenses will be accepted or issued between October 1,
21.8 2013, and December 31, 2013.

21.9 (d) Beginning October 1, 2013, changes in ownership applications will require
21.10 payment of the new fees listed in section 144A.472.

21.11 Subd. 2. **Current home care licensees with licenses prior to July 1, 2013.** (a)
21.12 Beginning July 1, 2014, department licensed home care providers must apply for either
21.13 the basic or comprehensive home care license on their regularly scheduled renewal date.

21.14 (b) By June 30, 2015, all home care providers must either have a basic or
21.15 comprehensive home care license or temporary license.

21.16 Subd. 3. **Renewal application of home care licensure during transition period.**
21.17 Renewal of home care licenses issued beginning July 1, 2014, will be issued according to
21.18 sections 144A.43 to 144A.4799 and, upon license renewal, providers must comply with
21.19 sections 144A.43 to 144A.4799. Prior to renewal, providers must comply with the home
21.20 care licensure law in effect on June 30, 2013.

21.21 The fees charged for licenses renewed between July 1, 2014, and June 30, 2016,
21.22 shall be the lesser of 200 percent or $1,000, except where the 200 percent or $1,000
21.23 increase exceeds the actual renewal fee charged, with a maximum renewal fee of $6,625.

21.24 For fiscal year 2014 only, the fees for providers with revenues greater than $25,000
21.25 and no more than $100,000 will be $313 and for providers with revenues no more than
21.26 $25,000 the fee will be $125.

21.27 Sec. ... **[144A.482] REGISTRATION OF HOME MANAGEMENT PROVIDERS.**

21.28 (a) For purposes of this section, a home management provider is an individual or
21.29 organization that provides at least two of the following services: housekeeping, meal
21.30 preparation, and shopping, to a person who is unable to perform these activities due to
21.31 illness, disability, or physical condition.

21.32 (b) A person or organization that provides only home management services may not
21.33 operate in the state without a current certificate of registration issued by the commissioner
21.34 of health. To obtain a certificate of registration, the person or organization must annually
21.35 submit to the commissioner the name, mailing and physical address, e-mail address, and

22.1 telephone number of the individual or organization and a signed statement declaring that
22.2 the individual or organization is aware that the home care bill of rights applies to their
22.3 clients and that the person or organization will comply with the home care bill of rights
22.4 provisions contained in section 144A.44. An individual or organization applying for a
22.5 certificate must also provide the name, business address, and telephone number of each of
22.6 the individuals responsible for the management or direction of the organization.

22.7 (c) The commissioner shall charge an annual registration fee of $20 for individuals
22.8 and $50 for organizations. The registration fee shall be deposited in the state treasury and
22.9 credited to the state government special revenue fund.

22.10 (d) A home care provider that provides home management services and other home
22.11 care services must be licensed, but licensure requirements other than the home care bill of
22.12 rights do not apply to those employees or volunteers who provide only home management
22.13 services to clients who do not receive any other home care services from the provider.
22.14 A licensed home care provider need not be registered as a home management service
22.15 provider, but must provide an orientation on the home care bill of rights to its employees
22.16 or volunteers who provide home management services.

22.17 (e) An individual who provides home management services under this section must,
22.18 within 120 days after beginning to provide services, attend an orientation session approved
22.19 by the commissioner that provides training on the home care bill of rights and an orientation
22.20 on the aging process and the needs and concerns of elderly and disabled persons.

22.21 (f) The commissioner may suspend or revoke a provider's certificate of registration
22.22 or assess fines for violation of the home care bill of rights. Any fine assessed for a
22.23 violation of the home care bill of rights by a provider registered under this section shall be
22.24 in the amount established in the licensure rules for home care providers. As a condition
22.25 of registration, a provider must cooperate fully with any investigation conducted by the
22.26 commissioner, including providing specific information requested by the commissioner on
22.27 clients served and the employees and volunteers who provide services. Fines collected
22.28 under this paragraph shall be deposited in the state treasury and credited to the fund
22.29 specified in the statute or rule in which the penalty was established.

22.30 (g) The commissioner may use any of the powers granted in sections 144A.43 to
22.31 144A.4799 to administer the registration system and enforce the home care bill of rights
22.32 under this section."

22.33 Page 94, delete section 1

22.34 Page 96, delete section 2

22.35 Page 97, delete section 3

22.36 Page 98, delete sections 4 to 6

23.1 Page 99 delete sections 7 to 9
23.2 Page 100, delete section 10
23.3 Page 104, delete section 11
23.4 Page 117, delete sections 15 and 16
23.5 Page 118, delete section 17
23.6 Page 120, after line 29, insert:

23.7 "**ARTICLE 6**
23.8 **CONTINUING CARE**

23.9 Section 1. Minnesota Statutes 2012, section 256.01, is amended by adding a
23.10 subdivision to read:
23.11 Subd. 35. **Commissioner must annually report certain prepaid medical**
23.12 **assistance plan data.** (a) The commissioner of human services and the commissioner
23.13 of education may share private or nonpublic data to allow the commissioners to analyze
23.14 the screening, diagnosis, and treatment of children with autism spectrum disorder and
23.15 other developmental conditions. The commissioners may share the individual-level data
23.16 necessary to:
23.17 (1) measure the prevalence of autism spectrum disorder and other developmental
23.18 conditions;
23.19 (2) analyze the effectiveness of existing policies and procedures in the early
23.20 identification of children with autism spectrum disorder and other developmental
23.21 conditions;
23.22 (3) assess the effectiveness of screening, diagnosis, and treatment to allow children
23.23 with autism spectrum disorder and other developmental conditions to meet developmental
23.24 and social-emotional milestones;
23.25 (4) identify and address disparities in screening, diagnosis, and treatment related
23.26 to the native language or race and ethnicity of the child;
23.27 (5) measure the effectiveness of public health care programs in addressing the medical
23.28 needs of children with autism spectrum disorder and other developmental conditions; and
23.29 (6) determine the capacity of educational systems and health care systems to meet
23.30 the needs of children with autism spectrum disorder and other developmental conditions.
23.31 (b) The commissioner of human services shall use the data shared with the
23.32 commissioner of education under this subdivision to improve public health care program
23.33 performance in early screening, diagnosis, and treatment for children once data are
23.34 available and shall report on the results and any summary data, as defined in section 13.02,
23.35 subdivision 19, on the department's public Web site by September 30 each year.

24.1 Sec. 2. **[256B.0949] AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.**

24.2 Subdivision 1. **Purpose.** This section creates a new benefit available under the
24.3 medical assistance state plan when federal approval consistent with the provisions in
24.4 subdivision 11 is obtained for a 1915(i) waiver pursuant to the Affordable Care Act, section
24.5 2402(c), amending United States Code, title 42, section 1396n(i)(1), or other option to
24.6 provide early intensive intervention to a child with an autism spectrum disorder diagnosis.
24.7 This benefit must provide coverage for diagnosis, multidisciplinary assessment, ongoing
24.8 progress evaluation, and medically necessary treatment of autism spectrum disorder.

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

24.11 (b) "Autism spectrum disorder diagnosis" is defined by diagnostic code 299 in the
24.12 current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

24.13 (c) "Child" means a person under the age of seven, or for two years at any age under
24.14 age 18 if the person was not diagnosed with autism spectrum disorder before age five, or a
24.15 person under age 18 pursuant to subdivision 12.

24.16 (d) "Commissioner" means the commissioner of human services, unless otherwise
24.17 specified.

24.18 (e) "Early intensive intervention benefit" means autism treatment options based in
24.19 behavioral and developmental science, which may include modalities such as applied
24.20 behavior analysis, developmental treatment approaches, and naturalistic and parent
24.21 training models.

24.22 (f) "Generalizable goals" means results or gains that are observed during a variety
24.23 of activities with different people, such as providers, family members, other adults, and
24.24 children, and in different environments including, but not limited to, clinics, homes,
24.25 schools, and the community.

24.26 Subd. 3. **Initial eligibility.** This benefit is available to a child enrolled in medical
24.27 assistance who:

24.28 (1) has an autism spectrum disorder diagnosis;

24.29 (2) has had a diagnostic assessment described in subdivision 5, which recommends
24.30 early intensive intervention services;

24.31 (3) meets the criteria for medically necessary autism early intensive intervention
24.32 services; and

24.33 (4) declines to enroll in the state services described in section 252.27.

24.34 Subd. 4. **Diagnosis.** (a) A diagnosis must:

24.35 (1) be based upon current DSM criteria including direct observations of the child
24.36 and reports from parents or primary caregivers;

25.1 (2) be completed by a professional who has expertise and training in autism spectrum
25.2 disorder and child development and who is a licensed physician, nurse practitioner, or
25.3 a licensed mental health professional until the commissioner's assessment required in
25.4 subdivision 8, clause (7), shows there are adequate professionals to avoid access problems
25.5 or delays in diagnosis for young children if two professionals are required for a diagnosis
25.6 pursuant to clause (3); and
25.7 (3) be completed by both a medical and mental health professional who have expertise
25.8 and training in autism spectrum disorder and child development when the assessment in
25.9 subdivision 8, clause (7), demonstrates that there are sufficient professionals available.
25.10 (b) Additional diagnostic assessment information including from special education
25.11 evaluations and licensed school personnel, and from professionals licensed in the fields of
25.12 medicine, speech and language, psychology, occupational therapy, and physical therapy
25.13 may be considered.
25.14 Subd. 5. **Diagnostic assessment.** The following information and assessments must
25.15 be performed, reviewed, and relied upon for the eligibility determination, treatment and
25.16 services recommendations, and treatment plan development for the child:
25.17 (1) an assessment of the child's developmental skills, functional behavior, needs,
25.18 and capacities based on direct observation of the child which must be administered by
25.19 a licensed mental health professional and may also include observations from family
25.20 members, licensed school personnel, child care providers, or other caregivers, as well as
25.21 any medical or assessment information from other licensed professionals such as the
25.22 child's physician, rehabilitation therapists, or mental health professionals; and
25.23 (2) an assessment of parental or caregiver capacity to participate in therapy including
25.24 the type and level of parental or caregiver involvement and training recommended.
25.25 Subd. 6. **Treatment plan.** (a) Each child's treatment plan must be:
25.26 (1) based on the diagnostic assessment information specified in subdivisions 4 and 5;
25.27 (2) coordinated with medically necessary occupational, physical, and speech and
25.28 language therapies, special education, and other services the child and family are receiving;
25.29 (3) family-centered;
25.30 (4) culturally sensitive; and
25.31 (5) individualized based on the child's developmental status and the child's and
25.32 family's identified needs.
25.33 (b) The treatment plan must specify the:
25.34 (1) child's goals which are developmentally appropriate, functional, and
25.35 generalizable;
25.36 (2) treatment modality;

26.1 (3) treatment intensity;
26.2 (4) setting; and
26.3 (5) level and type of parental or caregiver involvement.
26.4 (c) The treatment must be supervised by a professional with expertise and training in
26.5 autism and child development who is a licensed physician, nurse practitioner, or mental
26.6 health professional.
26.7 (d) The treatment plan must be submitted to the commissioner for approval in a
26.8 manner determined by the commissioner for this purpose.
26.9 (e) Services authorized must be consistent with the child's approved treatment plan.
26.10 Subd. 7. **Ongoing eligibility.** (a) An independent progress evaluation conducted
26.11 by a licensed mental health professional with expertise and training in autism spectrum
26.12 disorder and child development must be completed after each six months of treatment,
26.13 or more frequently as determined by the commissioner, to determine if progress is being
26.14 made toward achieving generalizable gains and meeting functional goals contained in
26.15 the treatment plan.
26.16 (b) The progress evaluation must include:
26.17 (1) the treating provider's report;
26.18 (2) parental or caregiver input;
26.19 (3) an independent observation of the child which can be performed by the child's
26.20 licensed special education staff;
26.21 (4) any treatment plan modifications; and
26.22 (5) recommendations for continued treatment services.
26.23 (c) Progress evaluations must be submitted to the commissioner in a manner
26.24 determined by the commissioner for this purpose.
26.25 (d) A child who continues to achieve generalizable gains and treatment goals as
26.26 specified in the treatment plan is eligible to continue receiving this benefit.
26.27 (e) A child's treatment shall continue during the progress evaluation and during an
26.28 appeal if continuation of services pending appeal have been requested pursuant to section
26.29 256.045, subdivision 10.
26.30 Subd. 8. **Refining the benefit with stakeholders.** The commissioner must develop
26.31 the implementation details of the benefit in consultation with stakeholders and consider
26.32 recommendations from the Health Services Advisory Council, the Department of Human
26.33 Services Autism Spectrum Disorder Advisory Council, the Legislative Autism Spectrum
26.34 Disorder Task Force, and the Interagency Task Force of the Departments of Health,
26.35 Education, and Human Services. The commissioner must release these details for a 30-day

27.1 public comment period prior to submission to the federal government for approval. The
27.2 implementation details include, but are not limited to, the following components:
27.3 (1) a definition of the qualifications, standards, and roles of the treatment team,
27.4 including recommendations after stakeholder consultation on whether board-certified
27.5 behavior analysts and other types of professionals trained in autism spectrum disorder and
27.6 child development should be added as mental health or other professionals for treatment
27.7 supervision or other function under medical assistance;
27.8 (2) development of initial, uniform parameters for comprehensive multidisciplinary
27.9 diagnostic assessment information and progress evaluation standards;
27.10 (3) the design of an effective and consistent process for assessing parent and
27.11 caregiver capacity to participate in the child's early intervention treatment and methods of
27.12 involving the parents in the treatment of the child;
27.13 (4) formulation of a collaborative process in which professionals have opportunities
27.14 to collectively inform the comprehensive, multidisciplinary diagnostic assessment and
27.15 progress evaluation processes and standards to support quality improvement of early
27.16 intensive intervention services;
27.17 (5) coordination of this benefit and its interaction with other services provided by the
27.18 Departments of Human Services, Health, and Education;
27.19 (6) evaluation, on an ongoing basis, of research regarding the program and treatment
27.20 modalities provided to children under this benefit; and
27.21 (7) determination of the availability of licensed medical and mental health
27.22 professionals with expertise and training in autism spectrum disorder throughout the state
27.23 in order to assess whether there are sufficient professionals to require involvement of
27.24 both a medical and mental health professional to provide access and prevent delay in the
27.25 diagnosis and treatment of young children so as to implement subdivision 4, paragraph
27.26 (a), and to ensure treatment is effective, timely, and accessible.
27.27 Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered
27.28 treatment options as needed based on outcome data and other evidence.
27.29 (b) Before the changes become effective, the commissioner must provide public
27.30 notice of the changes, the reasons for the change, and a 30-day public comment period
27.31 to those who request notice through an electronic list accessible to the public on the
27.32 department's Web site.
27.33 Subd. 10. **Coordination between agencies.** The commissioners of human services
27.34 and education must develop the capacity to coordinate services and information including
27.35 diagnostic, functional, developmental, medical, and educational assessments; service
27.36 delivery; and progress evaluations across health and education sectors.

28.1 Subd. 11. **Federal approval of the autism benefit.** The provisions of subdivision 9
28.2 shall apply to state plan services under Title XIX of the Social Security Act when federal
28.3 approval is granted under a 1915(i) waiver or other authority which allows children
28.4 eligible for medical assistance through the TEFRA option under section 256B.055,
28.5 subdivision 12, to qualify and includes children eligible for medical assistance in families
28.6 over 150 percent of the federal poverty guidelines.

28.7 Subd. 12. **Local school districts option to continue treatment.** (a) A local school
28.8 district may contract with the commissioner of human services to pay the state share of
28.9 the benefits described under this section to continue this treatment as part of the special
28.10 education services offered to all students in the district diagnosed with an autism spectrum
28.11 disorder.

28.12 (b) A local school district may utilize third-party billing to seek reimbursement
28.13 for the district for any services paid by the district under this section for which private
28.14 insurance coverage was available to the child.

28.15 **EFFECTIVE DATE.** The autism benefit under subdivisions 1 to 7, 9, and 12, is
28.16 effective upon federal approval for the benefit under a 1915(i) waiver or other federal
28.17 authority needed to meet the requirements of subdivision 11, but no earlier than March 1,
28.18 2014. Subdivisions 8, 10, and 11 are effective July 1, 2013.

28.19 Sec. 3. Minnesota Statutes 2012, section 256B.69, is amended by adding a subdivision
28.20 to read:

28.21 Subd. 32a. **Initiatives to improve early screening, diagnosis, and treatment of**
28.22 **children with autism spectrum disorder and other developmental conditions.** (a) The
28.23 commissioner shall require managed care plans and county-based purchasing plans, as
28.24 a condition of contract, to implement strategies that facilitate access for young children
28.25 between the ages of one and three years to periodic developmental and social-emotional
28.26 screenings, as recommended by the Minnesota Interagency Developmental Screening
28.27 Task Force, and that those children who do not meet milestones are provided access to
28.28 appropriate evaluation and assessment, including treatment recommendations, expected to
28.29 improve the child's functioning, with the goal of meeting milestones by age five.

28.30 (b) The managed care plans must report the following data annually:

28.31 (1) the number of children who received a diagnostic assessment;

28.32 (2) the total number of children ages one to six with a diagnosis of autism spectrum
28.33 disorder who received treatments;

28.34 (3) the number of children identified under clause (2) reported by each 12-month
28.35 age group beginning with age one and ending with age six;

29.1 (4) the types of treatments provided to children identified under clause (2) listed by
29.2 billing code, including the number of units billed for each child;
29.3 (5) barriers to providing screening, diagnosis, and treatment of young children
29.4 between the ages of one and three years and any strategies implemented to address
29.5 those barriers; and
29.6 (6) recommendations on how to measure and report on the effectiveness of the
29.7 strategies implemented to facilitate access for young children to provide developmental
29.8 and social-emotional screening, diagnosis, and treatment.

29.9 Sec. 4. **NURSING HOME LEVEL OF CARE REPORT.**
29.10 (a) The commissioner of human services shall report on the impact of the nursing
29.11 home level of care implementation including the following:
29.12 (1) the number of individuals who lost waivered services and medical assistance;
29.13 (2) the result of the loss of services;
29.14 (3) information on where individuals were living before and after the nursing home
29.15 level of care changes took effect to show the impact on an individual's ability to maintain
29.16 independence in the community; and
29.17 (4) utilization data before and after nursing home level of care implementation for
29.18 those who retained medical assistance including which essential community support
29.19 and personal care assistant services were used, and to what extent the $400 essential
29.20 community support grant was sufficient to meet needs.
29.21 (b) The commissioner of human services shall report to the chairs of the legislative
29.22 committees with jurisdiction over health and human services policy and finance with the
29.23 information required under paragraph (a) on October 1, 2014, and annually thereafter.

29.24 **ARTICLE 7**

29.25 **HOME AND COMMUNITY-BASED SERVICES DISABILITY RATE SETTING**

29.26 Section 1. **[256B.4914] HOME AND COMMUNITY-BASED SERVICES**
29.27 **WAIVERS; RATE SETTING.**
29.28 Subdivision 1. **Application.** The payment methodologies in this section apply to
29.29 home and community-based services waivers under sections 256B.092 and 256B.49. This
29.30 section does not change existing waiver policies and procedures.
29.31 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
29.32 meanings given them, unless the context clearly indicates otherwise.
29.33 (b) "Commissioner" means the commissioner of human services.

30.1 (c) "Component value" means underlying factors that are part of the cost of providing
30.2 services that are built into the waiver rates methodology to calculate service rates.
30.3 (d) "Customized living tool" means a methodology for setting service rates which
30.4 delineates and documents the amount of each component service included in a recipient's
30.5 customized living service plan.
30.6 (e) "Disability Waiver Rates System" means a statewide system which establishes
30.7 rates that are based on uniform processes and captures the individualized nature of waiver
30.8 services and recipient needs.
30.9 (f) "Lead agency" means a county, partnership of counties, or tribal agency charged
30.10 with administering waivered services under sections 256B.092 and 256B.49.
30.11 (g) "Median" means the amount that divides distribution into two equal groups, half
30.12 above the median and half below the median.
30.13 (h) "Payment or rate" means reimbursement to an eligible provider for services
30.14 provided to a qualified individual based on an approved service authorization.
30.15 (i) "Rates management system" means a web-based software application that uses
30.16 a framework and component values, as determined by the commissioner, to establish
30.17 service rates.
30.18 (j) "Recipient" means a person receiving home and community-based services
30.19 funded under any of the disability waivers.
30.20 Subd. 3. **Applicable services.** Applicable services are those authorized under the
30.21 state's home and community-based services waivers under sections 256B.092 and 256B.49
30.22 including, as defined in the federally approved home and community-based services plan:
30.23 (1) 24-hour customized living;
30.24 (2) adult day care;
30.25 (3) adult day care bath;
30.26 (4) behavioral programming;
30.27 (5) companion services;
30.28 (6) customized living;
30.29 (7) day training and habilitation;
30.30 (8) housing access coordination;
30.31 (9) independent living skills;
30.32 (10) in-home family support;
30.33 (11) night supervision;
30.34 (12) personal support;
30.35 (13) prevocational services;
30.36 (14) residential care services;

31.1 (15) residential support services;
31.2 (16) respite services;
31.3 (17) structured day services;
31.4 (18) supported employment services;
31.5 (19) supported living services;
31.6 (20) transportation services; and
31.7 (21) other services as approved by the federal government in the state home and
31.8 community-based services plan.
31.9 Subd. 4. **Data collection for rate determination.** (a) Rates for all applicable home
31.10 and community-based waivered services, including rate exceptions under subdivision 12
31.11 are set via the rates management system.
31.12 (b) Only data and information in the rates management system may be used to
31.13 calculate an individual's rate.
31.14 (c) Service providers, with information from the community support plan, shall enter
31.15 values and information needed to calculate an individual's rate into the rates management
31.16 system. These values and information include:
31.17 (1) shared staffing hours;
31.18 (2) individual staffing hours;
31.19 (3) staffing ratios;
31.20 (4) information to document variable levels of service qualification for variable
31.21 levels of reimbursement in each framework;
31.22 (5) shared or individualized arrangements for unit-based services, including the
31.23 staffing ratio; and
31.24 (6) number of trips and miles for transportation services.
31.25 (d) Updates to individual data shall include:
31.26 (1) data for each individual that is updated annually when renewing service plans; and
31.27 (2) requests by individuals or lead agencies to update a rate whenever there is a
31.28 change in an individual's service needs, with accompanying documentation.
31.29 (e) Lead agencies shall review and approve values to calculate the final payment rate
31.30 for each individual. Lead agencies must notify the individual and the service provider
31.31 of the final agreed upon values and rate. If a value used was mistakenly or erroneously
31.32 entered and used to calculate a rate, a provider may petition lead agencies to correct it.
31.33 Lead agencies must respond to these requests.
31.34 Subd. 5. **Base wage index and standard component values.** (a) The base wage
31.35 index is established to determine staffing costs associated with providing services to
31.36 individuals receiving home and community-based services. For purposes of developing

32.1 and calculating the proposed base wage, Minnesota-specific wages taken from job
32.2 descriptions and standard occupational classification (SOC) codes from the Bureau of
32.3 Labor Statistics, as defined in the most recent edition of the Occupational Handbook shall
32.4 be used. The base wage index shall be calculated as follows:

32.5 (1) for residential direct care basic staff, 50 percent of the median wage for personal
32.6 and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing
32.7 aide (SOC code 31-1012); and 20 percent of the median wage for social and human
32.8 services aide (SOC code 21-1093);

32.9 (2) for residential direct care intensive staff, 20 percent of the median wage for home
32.10 health aide (SOC code 31-1011); 20 percent of the median wage for personal and home
32.11 health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code
32.12 21-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
32.13 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

32.14 (3) for day services, 20 percent of the median wage for nursing aide (SOC Code
32.15 31-1012); 20 percent of the median wage for psychiatric technician (SOC Code 29-2053);
32.16 and 60 percent of the median wage for social and human services code (SOC Code
32.17 21-1093);

32.18 (4) for residential asleep overnight staff, the wage will be $7.66 per hour, except
32.19 in a family foster care setting the wage is $2.80 per hour;

32.20 (5) for behavior program analyst staff: 100 percent of the median wage for mental
32.21 health counselors (SOC code 21-1014);

32.22 (6) for behavior program professional staff: 100 percent of the median wage for
32.23 clinical counseling and school psychologist (SOC code 19-3031);

32.24 (7) for behavior program specialist staff: 100 percent of the median wage for
32.25 psychiatric technicians (SOC code 29-2053);

32.26 (8) for supportive living services staff: 20 percent of the median wage for nursing
32.27 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
32.28 code 29-2053); and 60 percent of the median wage for social and human services aide
32.29 (SOC code 21-1093);

32.30 (9) for housing access coordination staff: 50 percent of the median wage for
32.31 community and social services specialist (SOC code 21-1099); and 50 percent of the
32.32 median wage for social and human services aide (SOC code 21-1093);

32.33 (10) for in-home family support staff: 20 percent of the median wage for nursing
32.34 aide (SOC code 31-1012); 30 percent of community social service specialist (SOC code
32.35 21-1099); 40 percent of the median wage for social and human services aide (SOC code

33.1 21-1093); and 10 percent of the median wage for psychiatric technician (SOC code
33.2 29-2053);
33.3 (11) for independent living skills staff: 40 percent of the median wage for
33.4 community social service specialist (SOC code 21-1099); 50 percent of the median wage
33.5 for social and human services aide (SOC code 21-1093); and 10 percent of the median
33.6 wage for psychiatric technician (SOC code 29-2053);
33.7 (12) for supported employment staff: 20 percent of the median wage for nursing
33.8 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
33.9 code 29-2053); and 60 percent of the median wage for social and human services aide
33.10 (SOC code 21-1093);
33.11 (13) for adult companion staff: 50 percent of the median wage for personal and
33.12 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
33.13 orderlies, and attendants (SOC code 31-1012);
33.14 (14) for night supervision staff: 20 percent of the median wage for home health aide
33.15 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
33.16 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
33.17 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
33.18 percent of the median wage for social and human services aide (SOC code 21-1093);
33.19 (15) for respite staff: 50 percent of the median wage for personal and home care aide
33.20 (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and
33.21 attendants (SOC code 31-1012);
33.22 (16) for personal support staff: 50 percent of the median wage for personal and
33.23 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing
33.24 aides, orderlies, and attendants (SOC code 31-1012); and
33.25 (17) for supervisory staff: the basic wage is $17.43 per hour with exception of the
33.26 supervisor of behavior analyst and behavior specialists which shall be $30.75 per hour.
33.27 (b) Component values for residential support services, excluding family foster
33.28 care, are:
33.29 (1) supervisory span of control ratio: 11 percent;
33.30 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
33.31 (3) employee-related cost ratio: 23.6 percent;
33.32 (4) general administrative support ratio: 13.25 percent;
33.33 (5) program-related expense ratio: 1.3 percent; and
33.34 (6) absence and utilization factor ratio: 3.9 percent.
33.35 (c) Component values for family foster care are:
33.36 (1) supervisory span of control ratio: 11 percent;

34.1 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
34.2 (3) employee-related cost ratio: 23.6 percent;
34.3 (4) general administrative support ratio: 3.3 percent; and
34.4 (5) program-related expense ratio: 1.3 percent.
34.5 (d) Component values for day services for all services are:
34.6 (1) supervisory span of control ratio: 11 percent;
34.7 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
34.8 (3) employee-related cost ratio: 23.6 percent;
34.9 (4) program plan support ratio: 5.6 percent;
34.10 (5) client programming and support ratio: 10 percent;
34.11 (6) general administrative support ratio: 13.25 percent;
34.12 (7) program-related expense ratio: 1.8 percent; and
34.13 (8) absence and utilization factor ratio: 3.9 percent.
34.14 (e) Component values for unit-based with program services are:
34.15 (1) supervisory span of control ratio: 11 percent;
34.16 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
34.17 (3) employee-related cost ratio: 23.6 percent;
34.18 (4) program plan supports ratio: 3.1 percent;
34.19 (5) client programming and support ratio: 8.6 percent;
34.20 (6) general administrative support ratio: 13.25 percent;
34.21 (7) program-related expense ratio: 6.1 percent; and
34.22 (8) absence and utilization factor ratio: 3.9 percent.
34.23 (f) Component values for unit-based services without programming except respite
34.24 are:
34.25 (1) supervisory span of control ratio: 11 percent;
34.26 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
34.27 (3) employee-related cost ratio: 23.6 percent;
34.28 (4) program plan support ratio: 3.1 percent;
34.29 (5) client programming and support ratio: 8.6 percent;
34.30 (6) general administrative support ratio: 13.25 percent;
34.31 (7) program-related expense ratio: 6.1 percent; and
34.32 (8) absence and utilization factor ratio: 3.9 percent.
34.33 (g) Component values for unit-based services without programming for respite are:
34.34 (1) supervisory span of control ratio: 11 percent;
34.35 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
34.36 (3) employee-related cost ratio: 23.6 percent;

35.1 (4) general administrative support ratio: 13.25 percent;

35.2 (5) program-related expense ratio: 6.1 percent; and

35.3 (6) absence and utilization factor ratio: 3.9 percent.

35.4 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph
35.5 (a) based on the wage data by standard occupational code (SOC) from the Bureau of
35.6 Labor Statistics available on December 31, 2016. The commissioner shall publish these
35.7 updated values and load them into the rate management system. This adjustment shall
35.8 occur every five years. For adjustments in 2021 and beyond, the commissioner shall use
35.9 the data available on December 31 of the calendar year five years prior.

35.10 (i) On July 1, 2017, the commissioner shall update the framework components in
35.11 paragraph (c) for changes in the Consumer Price Index. The commissioner must adjust
35.12 these values higher or lower by the percentage change in the Consumer Price Index-All
35.13 Items (United States city average) (CPI-U) from January 1, 2014, to January 1, 2017. The
35.14 commissioner shall publish these updated values and load them into the rate management
35.15 system. This adjustment shall occur every five years. For adjustments in 2021 and
35.16 beyond, the commissioner shall use the data available on January 1 of the calendar year
35.17 four years prior and January 1 of the current calendar year.

35.18 Subd. 6. **Payments for residential support services.** (a) Payments for residential
35.19 support services, as defined in sections 256B.092, subdivision 11, and 256B.49 subdivision
35.20 22, must be calculated as follows:

35.21 (1) determine the number of units of service to meet a recipient's needs;

35.22 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
35.23 national and Minnesota-specific rates or rates derived by the commissioner as provided in
35.24 subdivision 5. This is defined as the direct care rate;

35.25 (3) for a recipient requiring customization for deaf or hard-of-hearing language
35.26 accessibility under subdivision 12, add the customization rate provided in subdivision 12
35.27 to the result of clause (2). This is defined as the customized direct care rate;

35.28 (4) multiply the number of residential services direct staff hours by the appropriate
35.29 staff wage in subdivision 5, paragraph (a), or the customized direct care rate;

35.30 (5) multiply the number of direct staff hours by the product of the supervision span
35.31 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
35.32 wage in subdivision 5, paragraph (a), clause (17);

35.33 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
35.34 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
35.35 clause (2). This is defined as the direct staffing cost;

36.1 (7) for employee-related expenses, multiply the direct staffing cost by one plus the
36.2 employee-related cost ratio in subdivision 5, paragraph (b), clause (3);
36.3 (8) for client programming and supports, the commissioner shall add $2,179; and
36.4 (9) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if
36.5 customized for adapted transport per year.
36.6 (b) The total rate shall be calculated using the following steps:
36.7 (1) subtotal paragraph (a), clauses (7) to (9);
36.8 (2) sum the standard general and administrative rate, the program-related expense
36.9 ratio, and the absence and utilization ratio; and
36.10 (3) divide the result of clause (1) by one minus the result of clause (2). This is
36.11 the total payment amount.
36.12 Subd. 7. **Payments for day programs.** Payments for services with day programs
36.13 including adult day care, day treatment and habilitation, prevocational services, and
36.14 structured day services must be calculated as follows:
36.15 (1) determine the number of units of service to meet a recipient's needs;
36.16 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
36.17 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;
36.18 (3) for a recipient requiring customization for deaf or hard-of-hearing language
36.19 accessibility under subdivision 12, add the customization rate provided in subdivision 12
36.20 to the result of clause (2). This is defined as the customized direct care rate;
36.21 (4) multiply the number of day program direct staff hours by the appropriate staff
36.22 wage in subdivision 5, paragraph (a), or the customized direct care rate;
36.23 (5) multiply the number of day program direct staff hours by the product of the
36.24 supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the
36.25 appropriate supervision wage in subdivision 5, paragraph (a), clause (17);
36.26 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
36.27 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d),
36.28 clause (2). This is defined as the direct staffing rate;
36.29 (7) for program plan support, multiply the result of clause (6) by one plus the
36.30 program plan support ratio in subdivision 5, paragraph (d), clause (4);
36.31 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
36.32 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);
36.33 (9) for client programming and supports, multiply the result of clause (8) by one plus
36.34 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);
36.35 (10) for program facility costs, add $8.30 per week with consideration of staffing
36.36 ratios to meet individual needs;

37.1 (11) for adult day bath services, add $7.01 per 15 minute unit;
37.2 (12) this is the subtotal rate;
37.3 (13) sum the standard general and administrative rate, the program-related expense
37.4 ratio, and the absence and utilization factor ratio;
37.5 (14) divide the result of clause (12) by one minus the result of clause (13). This is
37.6 the total payment amount;
37.7 (15) for transportation provided as part of day training and habilitation for an
37.8 individual who does not require a lift, add:
37.9 (i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle
37.10 without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared
37.11 ride in a vehicle with a lift;
37.12 (ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle
37.13 without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared
37.14 ride in a vehicle with a lift;
37.15 (iii) $25.75 for a trip between 21and 50 miles for a nonshared ride in a vehicle
37.16 without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared
37.17 ride in a vehicle with a lift; or
37.18 (iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a
37.19 lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a
37.20 vehicle with a lift;
37.21 (16) for transportation provide as part of day training and habilitation for an
37.22 individual who does require a lift, add:
37.23 (i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with
37.24 a lift, and $15.05 for a shared ride in a vehicle with a lift;
37.25 (ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
37.26 lift, and $28.16 for a shared ride in a vehicle with a lift;
37.27 (iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with
37.28 a lift, and $58.76 for a shared ride in a vehicle with a lift; or
37.29 (iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a
37.30 lift, and $80.93 for a shared ride in a vehicle with a lift.
37.31 Subd. 8. **Payments for unit-based services with programming.** Payments for
37.32 unit-based services with programming, including behavior programming, housing access
37.33 coordination, in-home family support, independent living skills training, hourly supported
37.34 living services, and supported employment provided to an individual outside of any day or
37.35 residential service plan must be calculated as follows, unless the services are authorized
37.36 separately under subdivision 6 or 7:

38.1 (1) determine the number of units of service to meet a recipient's needs;
38.2 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
38.3 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;
38.4 (3) for a recipient requiring customization for deaf or hard-of-hearing language
38.5 accessibility under subdivision 12, add the customization rate provided in subdivision 12
38.6 to the result of clause (2). This is defined as the customized direct care rate;
38.7 (4) multiply the number of direct staff hours by the appropriate staff wage in
38.8 subdivision 5, paragraph (a), or the customized direct care rate;
38.9 (5) multiply the number of direct staff hours by the product of the supervision span
38.10 of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
38.11 wage in subdivision 5, paragraph (a), clause (17);
38.12 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
38.13 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e),
38.14 clause (2). This is defined as the direct staffing rate;
38.15 (7) for program plan support, multiply the result of clause (6) by one plus the
38.16 program plan supports ratio in subdivision 5, paragraph (e), clause (4);
38.17 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
38.18 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);
38.19 (9) for client programming and supports, multiply the result of clause (8) by one plus
38.20 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);
38.21 (10) this is the subtotal rate;
38.22 (11) sum the standard general and administrative rate, the program-related expense
38.23 ratio, and the absence and utilization factor ratio; and
38.24 (12) divide the result of clause (10) by one minus the result of clause (11). This is
38.25 the total payment amount.
38.26 Subd. 9. **Payments for unit-based services without programming.** Payments
38.27 for unit-based without program services including night supervision, personal support,
38.28 respite, and companion care provided to an individual outside of any day or residential
38.29 service plan must be calculated as follows unless the services are authorized separately
38.30 under subdivision 6 or 7:
38.31 (1) for all services except respite, determine the number of units of service to meet
38.32 a recipient's needs;
38.33 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
38.34 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

39.1 (3) for a recipient requiring customization for deaf or hard-of-hearing language
39.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
39.3 to the result of clause (2). This is defined as the customized direct care rate;
39.4 (4) multiply the number of direct staff hours by the appropriate staff wage in
39.5 subdivision 5 or the customized direct care rate;
39.6 (5) multiply the number of direct staff hours by the product of the supervision span
39.7 of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
39.8 wage in subdivision 5, paragraph (a), clause (17);
39.9 (6) combine the results of clauses (4) and (5) and multiply the result by one plus
39.10 the employee vacation, sick, and training allowance ratio in, subdivision 5, paragraph (f),
39.11 clause (2). This is defined as the direct staffing rate;
39.12 (7) for program plan support, multiply the result of clause (6) by one plus the
39.13 program plan support ratio in subdivision 5, paragraph (f), clause (4);
39.14 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
39.15 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);
39.16 (9) For client programming and supports, multiply the result of clause (8) by one
39.17 plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);
39.18 (10) this is the subtotal rate;
39.19 (11) sum the standard general and administrative rate, the program-related expense
39.20 ratio, and the absence and utilization factor ratio;
39.21 (12) divide the result of clause (10) by one minus the result of clause (11). This is
39.22 the total payment amount;
39.23 (13) for respite services, determine the number of daily units of service to meet an
39.24 individual's needs;
39.25 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
39.26 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
39.27 (15) for a recipient requiring deaf or hard-of-hearing customization under
39.28 subdivision 12, add the customization rate provided in subdivision 12 to the result of
39.29 clause (14). This is defined as the customized direct care rate;
39.30 (16) multiply the number of direct staff hours by the appropriate staff wage in
39.31 subdivision 5, paragraph (a);
39.32 (17) multiply the number of direct staff hours by the product of the supervisory span
39.33 of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
39.34 wage in subdivision 5, paragraph (a), clause (17);

40.1 (18) combine the results of clauses (16) and (17) and multiply the result by one plus
40.2 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g),
40.3 clause (2). This is defined as the direct staffing rate;
40.4 (19) for employee-related expenses, multiply the result of clause (18) by one plus
40.5 the employee-related cost ratio in subdivision 5, paragraph (g), clause (3).
40.6 (20) this is the subtotal rate;
40.7 (21) sum the standard general and administrative rate, the program-related expense
40.8 ratio, and the absence and utilization factor ratio; and
40.9 (22) divide the result of clause (20) by one minus the result of clause (21). This is
40.10 the total payment amount.
40.11 Subd. 10. **Updating payment values and additional information.** (a) The
40.12 commissioner shall develop and implement uniform procedures to refine terms and update
40.13 or adjust values used to calculate payment rates in this section. For calendar year 2014,
40.14 the commissioner shall use the values, terms, and procedures provided in this section.
40.15 (b) The commissioner shall work with stakeholders to assess efficacy of values
40.16 and payment rates. The commissioner shall report back to the legislature with proposed
40.17 changes for component values and recommendations for revisions on the schedule
40.18 provided in paragraphs (c) and (d).
40.19 (c) The commissioner shall work with stakeholders to continue refining a
40.20 subset of component values, which are to be referred to as interim values, and report
40.21 recommendations to the legislature by February 15, 2014. Interim component values are:
40.22 transportation rates for day training and habilitation; transportation for adult day, structured
40.23 day, and prevocational services; geographic difference factor; day program facility rate;
40.24 services where monitoring technology replaces staff time; shared services for independent
40.25 living skills training; and supported employment and billing for indirect services.
40.26 (d) The commissioner shall report and make recommendations to the legislature on:
40.27 February 15, 2015, February 15, 2017, February 15, 2019, and February 15, 2021. After
40.28 2021, reports shall be provided on a four-year cycle.
40.29 (e) The commissioner shall provide a public notice via list serve in October of each
40.30 year beginning October 1, 2014. The notice shall contain information detailing legislatively
40.31 approved changes in: calculation values including derived wage rates and related employee
40.32 and administrative factors; services utilization; county and tribal allocation changes
40.33 and; information on adjustments to be made to calculation values and timing of those
40.34 adjustments. Information in this notice shall be effective January 1 of the following year.

41.1 Subd. 11. **Payment implementation.** Upon implementation of the payment
41.2 methodologies under this section, those payment rates supersede rates established in county
41.3 contracts for recipients receiving waiver services under sections 256B.092 or 256B.49.

41.4 Subd. 12. **Customization of rates for individuals.** (a) For persons determined to
41.5 have higher needs based on being deaf or hard-of-hearing, the direct care costs must be
41.6 increased by an adjustment factor prior to calculating the rate under subdivisions 6, 7, 8,
41.7 and 9. The customization rate with respect to deaf or hard-of-hearing persons shall be
41.8 $2.50 per hour for waiver recipients who meet the respective criteria as determined by
41.9 the commissioner.

41.10 (b) For the purposes of this section, "Deaf or Hard of Hearing" means:

41.11 (1)(i) the person has a developmental disability and an assessment score which
41.12 indicates a hearing impairment that is severe or that the person has no useful hearing;

41.13 (ii) the person has a developmental disability and an expressive communications
41.14 score that indicates the person uses single signs or gestures, uses an augmentative
41.15 communication aid, or does not have functional communication, or the person's expressive
41.16 communications are unknown; and

41.17 (iii) the person has a developmental disability and a communication score which
41.18 indicates the person comprehends signs, gestures, and modeling prompts or does not
41.19 comprehend verbal, visual, or gestural communication or that the person's receptive
41.20 communications score is unknown; or

41.21 (2)(i) the person receives long-term care services and has an assessment score which
41.22 indicates they hear only very loud sounds, have no useful hearing, or a determination
41.23 cannot be made; and

41.24 (ii) the person receives long-term care services and has an assessment which
41.25 indicates the person communicates needs with sign language, symbol board, written
41.26 messages, gestures or an interpreter; communicates with inappropriate content; makes
41.27 garbled sounds or displays echolalia; or does not communicate needs.

41.28 Subd. 13. **Transportation.** The commissioner shall require that the purchase
41.29 of transportation services be cost-effective and be limited to market rates where the
41.30 transportation mode is generally available and accessible.

41.31 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead
41.32 agencies must identify individuals with exceptional needs that cannot be met under the
41.33 disability waiver rate system. The commissioner shall use that information to evaluate
41.34 and, if necessary, approve an alternative payment rate for those individuals.

41.35 (b) Lead agencies must submit exception requests to the state.

41.36 (c) An application for a rate exception may be submitted for the following criteria:

42.1 (1) an individual has service needs that cannot be met through additional units
42.2 of service; or
42.3 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results in an
42.4 individual being discharged.
42.5 (d) Exception requests must include the following information:
42.6 (1) the service needs required by each individual that are not accounted for in
42.7 subdivisions 6, 7, 8, and 9;
42.8 (2) the service rate requested and the difference from the rate determined in
42.9 subdivisions 6, 7, 8, and 9;
42.10 (3) a basis for the underlying costs used for the rate exception and any accompanying
42.11 documentation;
42.12 (4) the duration of the rate exception; and
42.13 (5) any contingencies for approval.
42.14 (e) Approved rate exceptions shall be managed within lead agency allocations under
42.15 sections 256B.092 and 256B.49.
42.16 (f) Individual disability waiver recipients may request that a lead agency submit an
42.17 exception request. A lead agency that denies such a request shall notify the individual
42.18 waiver recipient of its decision and the reasons for denying the request in writing no later
42.19 than 30 days after the individual's request has been made.
42.20 (g) The commissioner shall determine whether to approve or deny an exception
42.21 request no more than 30 days after receiving the request. If the commissioner denies the
42.22 request, the commissioner shall notify the lead agency and the individual disability waiver
42.23 recipient in writing of the reasons for the denial.
42.24 (h) The individual disability waiver recipient may appeal any denial of an exception
42.25 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
42.26 256.0451. When the denial of an exception request results in the proposed demission of a
42.27 waiver recipient from a residential or day habilitation program, the commissioner shall
42.28 issue a temporary stay of demission, when requested by the disability waiver recipient,
42.29 consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c).
42.30 The temporary stay shall remain in effect until the lead agency can provide an informed
42.31 choice of appropriate, alternative services to the disability waiver.
42.32 (i) Providers may petition lead agencies to update values that were entered
42.33 incorrectly or erroneously into the rate management system, based on past service level
42.34 discussions and determination in subdivision 4, without applying for a rate exception.
42.35 Subd. 15. **County or tribal allocations.** (a) Upon implementation of the Disability
42.36 Waiver Rates Management System on January 1, 2014, the commissioner shall establish

43.1 a method of tracking and reporting the fiscal impact of the Disability Waiver Rates
43.2 Management System on individual lead agencies.

43.3 (b) Beginning January 1, 2014, and continuing through full implementation on
43.4 December 31, 2017, the commissioner shall make annual adjustments to lead agencies'
43.5 home and community-based waivered service budget allocations to adjust for rate
43.6 differences and the resulting impact on county allocations upon implementation of the
43.7 disability waiver rates system.

43.8 Subd. 16. **Budget neutrality adjustment.** The commissioner shall calculate the
43.9 total spending for all home and community-based waiver services under the payments as
43.10 defined in subdivisions 6, 7, 8, and 9 for all recipients as of July 1, 2013, and compare it to
43.11 spending for services defined for subdivisions 6, 7, 8, and 9 under current law. If spending
43.12 for services in one particular subdivision differs, there will be a percentage adjustment
43.13 to increase or decrease individual rates for the services defined in each subdivision so
43.14 aggregate spending matches projections under current law.

43.15 Subd. 17. **Implementation.** (a) On January 1, 2014, the commissioner shall fully
43.16 implement the calculation of rates for waivered services under sections 256B.092 and
43.17 256B.49, without additional legislative approval.

43.18 (b) The commissioner shall phase in the application of rates determined in
43.19 subdivisions 6 to 9 for two years.

43.20 (c) The commissioner shall preserve rates in effect on December 31, 2013, for
43.21 the two-year period.

43.22 (d) The commissioner shall calculate and measure the difference in cost per
43.23 individual using the historical rate and the rates under subdivisions 6 to 9, for all
43.24 individuals enrolled as of December 31, 2013. This measurement shall occur statewide,
43.25 and for individuals in every county.

43.26 The commissioner shall provide the results of this analysis, by county for calendar
43.27 year 2014, to the legislative committees with jurisdiction over health and human services
43.28 finance by February 15, 2015.

43.29 (e) The commissioner shall calculate the average rate per unit for each service by
43.30 county. For individuals enrolled after January 1, 2014, individuals will receive the higher
43.31 of the rate produced under subdivisions 6 to 9, or the by-county average rate.

43.32 (f) On January 1, 2016, the rates determined in subdivisions 6 to 9 shall be applied."

43.33 Renumber the sections in sequence and correct the internal references

43.34 Amend the title accordingly