

1.1 CONFERENCE COMMITTEE REPORT ON H. F. No. 1233

1.2 A bill for an act

1.3 relating to state government; establishing the health and human services budget;
1.4 modifying provisions related to health care, continuing care, human services
1.5 licensing, chemical and mental health, managed care organizations, waiver
1.6 provider standards, home care, and the Department of Health; redesigning home
1.7 and community-based services; establishing payment methodologies for home
1.8 and community-based services; adjusting nursing and ICF/DD facility rates;
1.9 setting and modifying fees; modifying autism coverage; modifying assistance
1.10 programs; requiring licensing of certain abortion facilities; requiring drug testing;
1.11 making technical changes; requiring studies; requiring reports; appropriating
1.12 money; amending Minnesota Statutes 2012, sections 16A.724, subdivisions
1.13 2, 3; 16C.10, subdivision 5; 16C.155, subdivision 1; 62A.65, subdivision
1.14 2, by adding a subdivision; 62J.692, subdivision 4; 62Q.19, subdivision 1;
1.15 103I.005, by adding a subdivision; 103I.521; 119B.13, subdivision 7; 144.051,
1.16 by adding subdivisions; 144.0724, subdivisions 4, 6; 144.123, subdivision 1;
1.17 144.125, subdivision 1; 144.966, subdivisions 2, 3a; 144.98, subdivisions 3, 5,
1.18 by adding subdivisions; 144.99, subdivision 4; 144A.351; 144A.43; 144A.44;
1.19 144A.45; 144A.53, subdivision 2; 144D.01, subdivision 4; 145.986; 145C.01,
1.20 subdivision 7; 148E.065, subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5,
1.21 16, 23, 27, 34, 35, 37, by adding subdivisions; 149A.03; 149A.65, by adding
1.22 subdivisions; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4;
1.23 149A.72, subdivisions 3, 9, by adding a subdivision; 149A.73, subdivisions 1,
1.24 2, 4; 149A.74; 149A.91, subdivision 9; 149A.93, subdivisions 3, 6; 149A.94;
1.25 149A.96, subdivision 9; 174.30, subdivision 1; 214.40, subdivision 1; 243.166,
1.26 subdivisions 4b, 7; 245.4661, subdivisions 5, 6; 245.4682, subdivision 2;
1.27 245A.02, subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 8, 9; 245A.04,
1.28 subdivision 13; 245A.042, subdivision 3; 245A.07, subdivisions 2a, 3; 245A.08,
1.29 subdivision 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435;
1.30 245A.144; 245A.1444; 245A.16, subdivision 1; 245A.40, subdivision 5;
1.31 245A.50; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245D.02;
1.32 245D.03; 245D.04; 245D.05; 245D.06; 245D.07; 245D.09; 245D.10; 246.18,
1.33 subdivision 8, by adding a subdivision; 246.54; 254B.04, subdivision 1;
1.34 254B.13; 256.01, subdivisions 2, 24, 34, by adding subdivisions; 256.9657,
1.35 subdivisions 1, 2, 3a; 256.9685, subdivision 2; 256.969, subdivisions 3a, 29;
1.36 256.975, subdivision 7, by adding subdivisions; 256.9754, subdivision 5, by
1.37 adding subdivisions; 256B.02, by adding subdivisions; 256B.021, by adding
1.38 subdivisions; 256B.04, subdivisions 18, 21, by adding a subdivision; 256B.055,
1.39 subdivisions 3a, 6, 10, 14, 15, by adding a subdivision; 256B.056, subdivisions 1,
1.40 1c, 3, 4, as amended, 5c, 10, by adding a subdivision; 256B.057, subdivisions 1,
1.41 8, 10, by adding a subdivision; 256B.06, subdivision 4; 256B.0623, subdivision
1.42 2; 256B.0625, subdivisions 9, 13e, 19c, 31, 39, 48, 58, by adding subdivisions;
1.43 256B.0631, subdivision 1; 256B.064, subdivisions 1a, 1b, 2; 256B.0659,

2.1 subdivision 21; 256B.0755, subdivision 3; 256B.0756; 256B.0911, subdivisions
 2.2 1, 1a, 3a, 4d, 6, 7, by adding a subdivision; 256B.0913, subdivision 4, by
 2.3 adding a subdivision; 256B.0915, subdivisions 3a, 5, by adding a subdivision;
 2.4 256B.0916, by adding a subdivision; 256B.0917, subdivisions 6, 13, by
 2.5 adding subdivisions; 256B.092, subdivisions 11, 12, by adding subdivisions;
 2.6 256B.0946; 256B.095; 256B.0951, subdivisions 1, 4; 256B.0952, subdivisions 1,
 2.7 5; 256B.097, subdivisions 1, 3; 256B.431, subdivision 44; 256B.434, subdivision
 2.8 4, by adding a subdivision; 256B.437, subdivision 6; 256B.439, subdivisions
 2.9 1, 2, 3, 4, by adding a subdivision; 256B.441, subdivisions 13, 53; 256B.49,
 2.10 subdivisions 11a, 12, 14, 15, by adding subdivisions; 256B.4912, subdivisions
 2.11 1, 2, 3, 7, by adding subdivisions; 256B.4913, subdivisions 5, 6, by adding a
 2.12 subdivision; 256B.492; 256B.493, subdivision 2; 256B.5011, subdivision 2;
 2.13 256B.5012, by adding subdivisions; 256B.69, subdivisions 5c, 31, by adding a
 2.14 subdivision; 256B.694; 256B.76, subdivisions 2, 4, by adding a subdivision;
 2.15 256B.761; 256B.764; 256B.766; 256D.024, by adding a subdivision; 256I.04,
 2.16 subdivision 3; 256I.05, subdivision 1e, by adding a subdivision; 256J.15, by
 2.17 adding a subdivision; 256J.26, subdivision 3, by adding a subdivision; 256J.35;
 2.18 256K.45; 256L.01, subdivisions 3a, 5, by adding subdivisions; 256L.02,
 2.19 subdivision 2, by adding subdivisions; 256L.03, subdivisions 1, 1a, 3, 5, 6, by
 2.20 adding a subdivision; 256L.04, subdivisions 1, 7, 8, 10, by adding subdivisions;
 2.21 256L.05, subdivisions 1, 2, 3; 256L.06, subdivision 3; 256L.07, subdivisions 1,
 2.22 2, 3; 256L.09, subdivision 2; 256L.11, subdivision 6; 256L.15, subdivisions 1, 2;
 2.23 257.0755, subdivision 1; 260B.007, subdivisions 6, 16; 260C.007, subdivisions
 2.24 6, 31; 270B.14, subdivision 1; 471.59, subdivision 1; 626.556, subdivisions 2, 3,
 2.25 10d; 626.557, subdivisions 4, 9, 9a, 9e; 626.5572, subdivision 13; Laws 1998,
 2.26 chapter 407, article 6, section 116; Laws 2011, First Special Session chapter 9,
 2.27 article 1, section 3; article 2, section 27; article 10, section 3, subdivision 3,
 2.28 as amended; proposing coding for new law in Minnesota Statutes, chapters 3;
 2.29 62A; 62D; 144; 144A; 145; 149A; 214; 245; 245A; 245D; 254B; 256; 256B;
 2.30 256L; repealing Minnesota Statutes 2012, sections 103I.005, subdivision 20;
 2.31 144.123, subdivision 2; 144A.46; 144A.461; 149A.025; 149A.20, subdivision
 2.32 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6;
 2.33 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a;
 2.34 149A.53, subdivision 9; 245A.655; 245B.01; 245B.02; 245B.03; 245B.031;
 2.35 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, 7; 245B.055; 245B.06; 245B.07;
 2.36 245B.08; 245D.08; 256B.055, subdivisions 3, 5, 10b; 256B.056, subdivision 5b;
 2.37 256B.057, subdivisions 1c, 2; 256B.0911, subdivisions 4a, 4b, 4c; 256B.0917,
 2.38 subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.096, subdivisions 1, 2, 3, 4;
 2.39 256B.14, subdivision 3a; 256B.49, subdivision 16a; 256B.4913, subdivisions 1,
 2.40 2, 3, 4; 256B.5012, subdivision 13; 256J.24, subdivision 6; 256K.45, subdivision
 2.41 2; 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, 10a;
 2.42 256L.05, subdivision 3b; 256L.07, subdivisions 5, 8, 9; 256L.11, subdivision 5;
 2.43 256L.12; 256L.17, subdivisions 1, 2, 3, 4, 5; 485.14; 609.093; Laws 2011, First
 2.44 Special Session chapter 9, article 7, section 54, as amended; Minnesota Rules,
 2.45 parts 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012; 4668.0016;
 2.46 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040; 4668.0050;
 2.47 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
 2.48 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160;
 2.49 4668.0170; 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220;
 2.50 4668.0230; 4668.0240; 4668.0800; 4668.0805; 4668.0810; 4668.0815;
 2.51 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840; 4668.0845;
 2.52 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001; 4669.0010;
 2.53 4669.0020; 4669.0030; 4669.0040; 4669.0050.

2.54
 2.55 The Honorable Paul Thissen
 2.56 Speaker of the House of Representatives

May 17, 2013

3.1 The Honorable Sandra L. Pappas
3.2 President of the Senate

3.3 We, the undersigned conferees for H. F. No. 1233 report that we have agreed upon
3.4 the items in dispute and recommend as follows:

3.5 That the Senate recede from its amendments and that H. F. No. 1233 be further
3.6 amended as follows:

3.7 Delete everything after the enacting clause and insert:

3.8 "ARTICLE 1

3.9 **AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH**
3.10 **CARE FOR MORE MINNESOTANS**

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

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

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

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

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

3.33 Persons with dependent children who are determined to be in need of chemical
3.34 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
3.35 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the

4.1 local agency to access needed treatment services. Treatment services must be appropriate
4.2 for the individual or family, which may include long-term care treatment or treatment in a
4.3 facility that allows the dependent children to stay in the treatment facility. The county
4.4 shall pay for out-of-home placement costs, if applicable.

4.5 (b) A person not entitled to services under paragraph (a), but with family income
4.6 that is less than 215 percent of the federal poverty guidelines for the applicable family
4.7 size, shall be eligible to receive chemical dependency fund services within the limit
4.8 of funds appropriated for this group for the fiscal year. If notified by the state agency
4.9 of limited funds, a county must give preferential treatment to persons with dependent
4.10 children who are in need of chemical dependency treatment pursuant to an assessment
4.11 under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision
4.12 6, or 260C.212. A county may spend money from its own sources to serve persons under
4.13 this paragraph. State money appropriated for this paragraph must be placed in a separate
4.14 account established for this purpose.

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

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

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

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

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

5.1 (2) Medicaid funding; and
5.2 (3) other funding sources identified by the commissioner that support coverage or
5.3 care redesign in Minnesota.

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

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

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

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

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

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

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

5.22 (e) The commissioner shall report to the chairs and ranking minority members of
5.23 the legislative committees with jurisdiction over health and human services policy and
5.24 financing by January 15, 2015, on the progress of receiving a federal waiver and shall
5.25 make recommendations on any legislative changes necessary to accomplish the project
5.26 in this subdivision. Any implementation of the waiver that requires a state financial
5.27 contribution to operate a health coverage program for Minnesotans with incomes between
5.28 200 and 275 percent of the federal poverty guidelines, shall be contingent on legislative
5.29 action approving the contribution.

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

5.32 Sec. 4. Minnesota Statutes 2012, section 256.015, subdivision 1, is amended to read:

5.33 Subdivision 1. **State agency has lien.** When the state agency provides, pays for, or
5.34 becomes liable for medical care or furnishes subsistence or other payments to a person,
5.35 the agency shall have a lien for the cost of the care and payments on any and all causes of

6.1 action or recovery rights under any policy, plan, or contract providing benefits for health
6.2 care or injury which accrue to the person to whom the care or payments were furnished,
6.3 or to the person's legal representatives, as a result of the occurrence that necessitated the
6.4 medical care, subsistence, or other payments. For purposes of this section, "state agency"
6.5 includes prepaid health plans under contract with the commissioner according to sections
6.6 256B.69, 256D.03, subdivision 4, paragraph (c), ~~and~~ 256L.12, 256L.01, subdivision 7,
6.7 and 256L.03, subdivision 6; children's mental health collaboratives under section 245.493;
6.8 demonstration projects for persons with disabilities under section 256B.77; nursing
6.9 homes under the alternative payment demonstration project under section 256B.434; and
6.10 county-based purchasing entities under section 256B.692.

6.11 Sec. 5. Minnesota Statutes 2012, section 256B.02, subdivision 17, as added by Laws
6.12 2013, chapter 1, section 1, is amended to read:

6.13 Subd. 17. **Affordable Care Act or ACA.** "Affordable Care Act" or "ACA" means
6.14 ~~Public Law 111-148, as amended by the federal Health Care and Education Reconciliation~~
6.15 ~~Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance~~
6.16 ~~issued under, those acts~~ means the federal Patient Protection and Affordable Care Act,
6.17 Public Law 111-148, as amended, including the federal Health Care and Education
6.18 Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal
6.19 guidance or regulations issued under, these acts.

6.20 **EFFECTIVE DATE.** This section is effective July 1, 2013.

6.21 Sec. 6. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
6.22 to read:

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

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

6.27 Sec. 7. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
6.28 to read:

6.29 Subd. 19. **Insurance affordability program.** "Insurance affordability program"
6.30 means one of the following programs:

6.31 (1) medical assistance under this chapter;

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

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

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

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

7.7 Sec. 8. Minnesota Statutes 2012, section 256B.04, subdivision 18, is amended to read:

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

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

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

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

7.20 Sec. 9. Minnesota Statutes 2012, section 256B.055, subdivision 3a, is amended to read:

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

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

7.30 Sec. 10. Minnesota Statutes 2012, section 256B.055, subdivision 6, is amended to read:

7.31 Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid
7.32 for a pregnant woman who ~~has written verification of a positive pregnancy test from a~~

8.1 ~~physician or licensed registered nurse, who~~ meets the other eligibility criteria of this
8.2 section and whose unborn child would be eligible as a needy child under subdivision 10 if
8.3 born and living with the woman. In accordance with Code of Federal Regulations, title
8.4 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless
8.5 the agency has information that is not reasonably compatible with such attestation. For
8.6 purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

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

8.8 Sec. 11. Minnesota Statutes 2012, section 256B.055, subdivision 10, is amended to read:

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

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

8.16 Sec. 12. Minnesota Statutes 2012, section 256B.055, subdivision 15, is amended to read:

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

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

8.20 (2) not pregnant;

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

8.23 (4) ~~not an adult in a family with children as defined in section 256L.01, subdivision~~
8.24 ~~3a; and~~ not otherwise eligible under subdivision 7 as a person who meets the categorical
8.25 eligibility requirements of the supplemental security income program;

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

8.29 (5) (6) not described in another subdivision of this section.

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

8.31 Sec. 13. Minnesota Statutes 2012, section 256B.055, is amended by adding a
8.32 subdivision to read:

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

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

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

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

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

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

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

9.16 ~~(2) For applications processed within one calendar month prior to July 1, 2003,~~
9.17 ~~eligibility shall be determined by applying the income standards and methodologies in~~
9.18 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July~~
9.19 ~~1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any~~
9.20 ~~months in the six-month budget period on or after that date. The income standards for~~
9.21 ~~each month shall be added together and compared to the applicant's total countable income~~
9.22 ~~for the six-month budget period to determine eligibility.~~

9.23 ~~(3) For children ages one through 18 whose eligibility is determined under section~~
9.24 ~~256B.057, subdivision 2, the following deductions shall be applied to income counted~~
9.25 ~~toward the child's eligibility as allowed under the state's AFDC plan in effect as of July~~
9.26 ~~16, 1996: \$90 work expense, dependent care, and child support paid under court order.~~
9.27 ~~This clause is effective October 1, 2003.~~

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

10.1 ~~(e) If the four-month disregard in paragraph (b) has been applied to the wage~~
10.2 ~~earner's income for four months, the disregard shall not be applied again until the wage~~
10.3 ~~earner's income has not been considered in determining medical assistance eligibility for~~
10.4 ~~12 consecutive months.~~

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

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

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

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

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

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

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

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

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

11.1 (5) for a person who no longer qualifies as an employed person with a disability due
11.2 to loss of earnings, assets allowed while eligible for medical assistance under section
11.3 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month
11.4 of ineligibility as an employed person with a disability, to the extent that the person's total
11.5 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

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

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

11.22 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
11.23 15.

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

11.25 Sec. 17. Minnesota Statutes 2012, section 256B.056, subdivision 4, as amended by
11.26 Laws 2013, chapter 1, section 5, is amended to read:

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

11.32 ~~(b) To be eligible for medical assistance, families and children may have an income~~
11.33 ~~up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,~~
11.34 ~~AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,~~
11.35 ~~1996, shall be increased by three percent.~~

12.1 (e) (b) Effective January 1, 2014, to be eligible for medical assistance, under section
12.2 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
12.3 percent of the federal poverty guidelines for the household size.

12.4 (d) (c) To be eligible for medical assistance under section 256B.055, subdivision
12.5 15, a person may have an income up to 133 percent of federal poverty guidelines for
12.6 the household size.

12.7 (e) (d) To be eligible for medical assistance under section 256B.055, subdivision
12.8 16, a child age 19 to 20 may have an income up to 133 percent of the federal poverty
12.9 guidelines for the household size.

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

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

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

12.26 Sec. 18. Minnesota Statutes 2012, section 256B.056, subdivision 5c, is amended to read:

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

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

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

13.1 Sec. 19. Minnesota Statutes 2012, section 256B.056, is amended by adding a
13.2 subdivision to read:

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

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

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

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

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

13.20 Sec. 20. Minnesota Statutes 2012, section 256B.056, subdivision 10, is amended to read:

13.21 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who
13.22 are applying for the continuation of medical assistance coverage following the end of the
13.23 60-day postpartum period to update their income and asset information and to submit
13.24 any required income or asset verification.

13.25 (b) The commissioner shall determine the eligibility of private-sector health care
13.26 coverage for infants less than one year of age eligible under section 256B.055, subdivision
13.27 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage
13.28 if this is determined to be cost-effective.

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

13.31 (d) The commissioner shall utilize information obtained through the electronic
13.32 service established by the secretary of the United States Department of Health and Human
13.33 Services and other available electronic data sources in Code of Federal Regulations, title
13.34 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner
13.35 shall establish standards to define when information obtained electronically is reasonably

14.1 compatible with information provided by applicants and enrollees, including use of
14.2 self-attestation, to accomplish real-time eligibility determinations and maintain program
14.3 integrity.

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

14.5 Sec. 21. Minnesota Statutes 2012, section 256B.057, subdivision 1, is amended to read:

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

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

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

14.25 (2) ~~For applications processed within one calendar month prior to July 1, 2003,~~
14.26 ~~eligibility shall be determined by applying the income standards and methodologies in~~
14.27 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July 1,~~
14.28 ~~2003, and the income standards and methodologies in effect on the expiration date for any~~
14.29 ~~months in the six-month budget period on or after July 1, 2003. The income standards~~
14.30 ~~for each month shall be added together and compared to the applicant's total countable~~
14.31 ~~income for the six-month budget period to determine eligibility.~~

14.32 (3) ~~An amount equal to the amount of earned income exceeding 275 percent of~~
14.33 ~~the federal poverty guideline, up to a maximum of the amount by which the combined~~
14.34 ~~total of 185 percent of the federal poverty guideline plus the earned income disregards~~
14.35 ~~and deductions allowed under the state's AFDC plan as of July 16, 1996, as required~~

15.1 ~~by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public~~
15.2 ~~Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for~~
15.3 ~~pregnant women and infants less than one year of age.~~

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

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

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

15.10 Sec. 22. Minnesota Statutes 2012, section 256B.057, subdivision 8, is amended to read:

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

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

15.17 Sec. 23. Minnesota Statutes 2012, section 256B.057, subdivision 10, is amended to read:

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

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

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

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

15.28 (4) is under age 65;

15.29 (5) is not otherwise eligible for medical assistance under United States Code, title
15.30 42, section 1396a(a)(10)(A)(i); and

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

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

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

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

16.8 Sec. 24. Minnesota Statutes 2012, section 256B.057, is amended by adding a
16.9 subdivision to read:

16.10 **Subd. 12. Presumptive eligibility determinations made by qualified hospitals.**

16.11 The commissioner shall establish a process to qualify hospitals that are participating
16.12 providers under the medical assistance program to determine presumptive eligibility for
16.13 medical assistance for applicants who may have a basis of eligibility using the modified
16.14 adjusted gross income methodology as defined in section 256B.056, subdivision 1a,
16.15 paragraph (b), clause (1).

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

16.17 Sec. 25. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

17.12 (c) All qualified noncitizens who were residing in the United States before August
17.13 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
17.14 medical assistance with federal financial participation.

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

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

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

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

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

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

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

17.35 (e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
17.36 are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this

18.1 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
18.2 Code, title 8, section 1101(a)(15).

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

18.7 (g) For purposes of this subdivision, the term "emergency medical condition" means
18.8 a medical condition that meets the requirements of United States Code, title 42, section
18.9 1396b(v).

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

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

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

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

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

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

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

18.24 (iii) services for routine prenatal care;

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

18.27 (v) elective surgery;

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

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

18.31 (viii) dialysis;

18.32 (ix) chemotherapy or therapeutic radiation services;

18.33 (x) rehabilitation services;

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

18.35 (xii) transportation services;

18.36 (xiii) case management;

- 19.1 (xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
- 19.2 (xv) dental services;
- 19.3 (xvi) hospice care;
- 19.4 (xvii) audiology services and hearing aids;
- 19.5 (xviii) podiatry services;
- 19.6 (xix) chiropractic services;
- 19.7 (xx) immunizations;
- 19.8 (xxi) vision services and eyeglasses;
- 19.9 (xxii) waiver services;
- 19.10 (xxiii) individualized education programs; or
- 19.11 (xxiv) chemical dependency treatment.

19.12 (i) ~~Beginning July 1, 2009, Pregnant noncitizens who are undocumented,~~
19.13 ~~nonimmigrants, or lawfully present in the United States as defined in Code of Federal~~
19.14 ~~Regulations, title 8, section 103.12, ineligible for federally funded medical assistance~~
19.15 ~~because of immigration status,~~ are not covered by a group health plan or health insurance
19.16 coverage according to Code of Federal Regulations, title 42, section 457.310, and who
19.17 otherwise meet the eligibility requirements of this chapter, are eligible for medical
19.18 assistance through the period of pregnancy, including labor and delivery, and 60 days
19.19 postpartum, to the extent federal funds are available under title XXI of the Social Security
19.20 Act, and the state children's health insurance program.

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

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

19.28 Sec. 26. Minnesota Statutes 2012, section 256B.0755, subdivision 3, is amended to read:

19.29 Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility
19.30 for the quality of care based on standards established under subdivision 1, paragraph (b),
19.31 clause (10), and the cost of care or utilization of services provided to its enrollees under
19.32 subdivision 1, paragraph (b), clause (1).

19.33 (b) A health care delivery system may contract and coordinate with providers and
19.34 clinics for the delivery of services and shall contract with community health clinics,

20.1 federally qualified health centers, community mental health centers or programs, county
20.2 agencies, and rural clinics to the extent practicable.

20.3 (c) A health care delivery system must indicate how it will coordinate with other
20.4 services affecting its patients' health, quality of care, and cost of care that are provided by
20.5 other providers, county agencies, and other organizations in the local service area. The
20.6 health care delivery system must indicate how it will engage other providers, counties, and
20.7 organizations, including county-based purchasing plans, that provide services to patients
20.8 of the health care delivery system on issues related to local population health, including
20.9 applicable local needs, priorities, and public health goals. The health care delivery system
20.10 must describe how local providers, counties, organizations, including county-based
20.11 purchasing plans, and other relevant purchasers were consulted in developing the
20.12 application to participate in the demonstration project.

20.13 **EFFECTIVE DATE.** This section is effective July 1, 2013, and applies to health
20.14 care delivery system contracts entered into on or after that date.

20.15 Sec. 27. Minnesota Statutes 2012, section 256B.694, is amended to read:

20.16 **256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE**
20.17 **CONTRACT.**

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

20.19 (b) The commissioner shall consider, and may approve, contracting on a
20.20 single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified
20.21 health plans that have coordination arrangements with counties, to serve persons ~~with a~~
20.22 ~~disability who voluntarily enroll~~ enrolled in state public health care programs, in order
20.23 to promote better coordination or integration of health care services, social services and
20.24 other community-based services, provided that all requirements applicable to health plan
20.25 purchasing, including those in ~~section 256B.69, subdivision 23~~ sections 256B.69 and
20.26 256B.692, are satisfied. ~~Nothing in this paragraph supersedes or modifies the requirements~~
20.27 ~~in paragraph (a).~~

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

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

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

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

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

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

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

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

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

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

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

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

21.29 Sec. 31. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
21.30 to read:

21.31 Subd. 6. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace"
21.32 means the Minnesota Insurance Marketplace as defined in section 62V.02.

22.1 Sec. 32. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
22.2 to read:

22.3 Subd. 7. **Participating entity.** "Participating entity" means a health carrier as
22.4 defined in section 62A.01, subdivision 2; a county-based purchasing plan established
22.5 under section 256B.692; an accountable care organization or other entity operating a
22.6 health care delivery systems demonstration project authorized under section 256B.0755;
22.7 an entity operating a county integrated health care delivery network pilot project
22.8 authorized under section 256B.0756; or a network of health care providers established to
22.9 offer services under MinnesotaCare.

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

22.11 Sec. 33. Minnesota Statutes 2012, section 256L.02, subdivision 2, is amended to read:

22.12 Subd. 2. **Commissioner's duties.** (a) The commissioner shall establish an office
22.13 for the state administration of this plan. The plan shall be used to provide covered health
22.14 services for eligible persons. Payment for these services shall be made to all ~~eligible~~
22.15 providers participating entities under contract with the commissioner. The commissioner
22.16 shall adopt rules to administer the MinnesotaCare program. The commissioner shall
22.17 establish marketing efforts to encourage potentially eligible persons to receive information
22.18 about the program and about other medical care programs administered or supervised by
22.19 the Department of Human Services.

22.20 (b) A toll-free telephone number and Web site must be used to provide information
22.21 about medical programs and to promote access to the covered services.

22.22 **EFFECTIVE DATE.** Paragraph (a) is effective January 1, 2015. Paragraph (b) is
22.23 effective January 1, 2014, or upon federal approval, whichever is later. The commissioner
22.24 of human services shall notify the revisor of statutes when federal approval is obtained.

22.25 Sec. 34. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision
22.26 to read:

22.27 Subd. 6. **Federal approval.** (a) The commissioner of human services shall seek
22.28 federal approval to implement the MinnesotaCare program under this chapter as a basic
22.29 health program. In any agreement with the Centers for Medicare and Medicaid Services
22.30 to operate MinnesotaCare as a basic health program, the commissioner shall seek to
22.31 include procedures to ensure that federal funding is predictable, stable, and sufficient
22.32 to sustain ongoing operation of MinnesotaCare. These procedures must address issues
22.33 related to the timing of federal payments, payment reconciliation, enrollee risk adjustment,

23.1 and minimization of state financial risk. The commissioner shall consult with the
23.2 commissioner of management and budget, when developing the proposal for establishing
23.3 MinnesotaCare as a basic health program to be submitted to the Centers for Medicare
23.4 and Medicaid Services.

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

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

23.13 Sec. 35. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision
23.14 to read:

23.15 Subd. 7. **Coordination with Minnesota Insurance Marketplace.** MinnesotaCare
23.16 shall be considered a public health care program for purposes of chapter 62V.

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

23.18 Sec. 36. Minnesota Statutes 2012, section 256L.03, subdivision 1, is amended to read:

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

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

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

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

24.1 Sec. 37. Minnesota Statutes 2012, section 256L.03, subdivision 1a, is amended to read:

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

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

24.15 Sec. 38. Minnesota Statutes 2012, section 256L.03, subdivision 3, is amended to read:

24.16 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
24.17 inpatient hospital services, including inpatient hospital mental health services and inpatient
24.18 hospital and residential chemical dependency treatment, subject to those limitations
24.19 necessary to coordinate the provision of these services with eligibility under the medical
24.20 assistance spenddown. ~~The inpatient hospital benefit for adult enrollees who qualify under~~
24.21 ~~section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and~~
24.22 ~~2, with family gross income that exceeds 200 percent of the federal poverty guidelines or~~
24.23 ~~215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not~~
24.24 ~~pregnant, is subject to an annual limit of \$10,000.~~

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

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

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

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

25.4 Sec. 39. Minnesota Statutes 2012, section 256L.03, is amended by adding a subdivision
25.5 to read:

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

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

25.10 Sec. 40. Minnesota Statutes 2012, section 256L.03, subdivision 5, is amended to read:

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

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

25.16 ~~(2) (1) \$3 per prescription for adult enrollees;~~

25.17 ~~(3) (2) \$25 for eyeglasses for adult enrollees;~~

25.18 ~~(4) (3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means~~
25.19 ~~an episode of service which is required because of a recipient's symptoms, diagnosis, or~~
25.20 ~~established illness, and which is delivered in an ambulatory setting by a physician or~~
25.21 ~~physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,~~
25.22 ~~audiologist, optician, or optometrist;~~

25.23 ~~(5) (4) \$6 for nonemergency visits to a hospital-based emergency room for services~~
25.24 ~~provided through December 31, 2010, and \$3.50 effective January 1, 2011; and~~

25.25 ~~(6) (5) a family deductible equal to the maximum amount allowed under Code of~~
25.26 ~~Federal Regulations, title 42, part 447.54.~~

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

25.29 ~~(e) (b) Paragraph (a) does not apply to pregnant women and children under the~~
25.30 ~~age of 21.~~

25.31 ~~(d) (c) Paragraph (a), clause (4) (3), does not apply to mental health services.~~

25.32 ~~(e) Adult enrollees with family gross income that exceeds 200 percent of the federal~~
25.33 ~~poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,~~

26.1 and who are not pregnant shall be financially responsible for the coinsurance amount, if
26.2 applicable, and amounts which exceed the \$10,000 inpatient hospital benefit limit.

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

26.8 ~~(g)~~ (d) MinnesotaCare reimbursements to fee-for-service providers and payments to
26.9 managed care plans or county-based purchasing plans shall not be increased as a result of
26.10 the reduction of the co-payments in paragraph (a), clause ~~(5)~~ (4), effective January 1, 2011.

26.11 ~~(h)~~ (e) The commissioner, through the contracting process under section 256L.12,
26.12 may allow managed care plans and county-based purchasing plans to waive the family
26.13 deductible under paragraph (a), clause ~~(6)~~ (5). The value of the family deductible shall not
26.14 be included in the capitation payment to managed care plans and county-based purchasing
26.15 plans. Managed care plans and county-based purchasing plans shall certify annually to the
26.16 commissioner the dollar value of the family deductible.

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

26.20 Sec. 41. Minnesota Statutes 2012, section 256L.03, subdivision 6, is amended to read:

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

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

26.31 Sec. 42. Minnesota Statutes 2012, section 256L.04, subdivision 1, is amended to read:

26.32 Subdivision 1. **Families with children.** (a) Families with children with family
26.33 income above 133 percent of the federal poverty guidelines and equal to or less than 275

27.1 200 percent of the federal poverty guidelines for the applicable family size shall be eligible
27.2 for MinnesotaCare according to this section. All other provisions of sections 256L.01 to
27.3 256L.18, including the insurance-related barriers to enrollment under section 256L.07,
27.4 shall apply unless otherwise specified. Children under age 19 with family income at or
27.5 below 200 percent of the federal poverty guidelines and who are ineligible for medical
27.6 assistance by sole reason of the application of federal household composition rules for
27.7 medical assistance are eligible for MinnesotaCare.

27.8 ~~(b) Parents who enroll in the MinnesotaCare program must also enroll their children,~~
27.9 ~~if the children are eligible. Children may be enrolled separately without enrollment by~~
27.10 ~~parents. However, if one parent in the household enrolls, both parents must enroll, unless~~
27.11 ~~other insurance is available. If one child from a family is enrolled, all children must~~
27.12 ~~be enrolled, unless other insurance is available. If one spouse in a household enrolls,~~
27.13 ~~the other spouse in the household must also enroll, unless other insurance is available.~~
27.14 ~~Families cannot choose to enroll only certain uninsured members.~~

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

27.18 ~~(d) Parents are not eligible for MinnesotaCare if their gross income exceeds \$57,500.~~

27.19 ~~(e) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision~~
27.20 ~~8, are exempt from the eligibility requirements of this subdivision.~~

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

27.24 Sec. 43. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision
27.25 to read:

27.26 Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare,
27.27 a person must meet the eligibility requirements of this section. A person eligible for
27.28 MinnesotaCare shall not be considered a qualified individual under section 1312 of the
27.29 Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered
27.30 through the Minnesota Insurance Marketplace under chapter 62V.

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

27.32 Sec. 44. Minnesota Statutes 2012, section 256L.04, subdivision 7, is amended to read:

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

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

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

28.11 Sec. 45. Minnesota Statutes 2012, section 256L.04, subdivision 8, is amended to read:

28.12 Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals
28.13 who receive supplemental security income or retirement, survivors, or disability benefits
28.14 due to a disability, or other disability-based pension, who qualify under subdivision 7, but
28.15 who are potentially eligible for medical assistance without a spenddown shall be allowed
28.16 to enroll in MinnesotaCare ~~for a period of 60 days~~, so long as the applicant meets all other
28.17 conditions of eligibility. The commissioner shall identify and refer the applications of
28.18 such individuals to their county social service agency. The county and the commissioner
28.19 shall cooperate to ensure that the individuals obtain medical assistance coverage for any
28.20 months for which they are eligible.

28.21 (b) The enrollee must cooperate with the county social service agency in determining
28.22 medical assistance eligibility ~~within the 60-day enrollment period~~. Enrollees who do not
28.23 cooperate with medical assistance ~~within the 60-day enrollment period~~ shall be disenrolled
28.24 from the plan within one calendar month. Persons disenrolled for nonapplication for
28.25 medical assistance may not reenroll until they have obtained a medical assistance
28.26 eligibility determination. Persons disenrolled for noncooperation with medical assistance
28.27 may not reenroll until they have cooperated with the county agency and have obtained a
28.28 medical assistance eligibility determination.

28.29 (c) ~~Beginning January 1, 2000,~~ Counties that choose to become MinnesotaCare
28.30 enrollment sites shall consider MinnesotaCare applications to also be applications for
28.31 medical assistance. ~~Applicants who are potentially eligible for medical assistance, except~~
28.32 ~~for those described in paragraph (a), may choose to enroll in either MinnesotaCare or~~
28.33 ~~medical assistance.~~

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

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

29.7 Sec. 46. Minnesota Statutes 2012, section 256L.04, subdivision 10, is amended to read:

29.8 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to
29.9 citizens or nationals of the United States, ~~qualified noncitizens, and other persons residing~~
29.10 and lawfully in the United States present noncitizens as defined in Code of Federal
29.11 Regulations, title 8, section 103.12. Undocumented noncitizens ~~and nonimmigrants~~
29.12 are ineligible for MinnesotaCare. For purposes of this subdivision, ~~a nonimmigrant~~
29.13 ~~is an individual in one or more of the classes listed in United States Code, title 8,~~
29.14 ~~section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the~~
29.15 United States without the approval or acquiescence of the United States Citizenship and
29.16 Immigration Services. Families with children who are citizens or nationals of the United
29.17 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
29.18 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
29.19 Public Law 109-171.

29.20 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and
29.21 individuals who are lawfully present and ineligible for medical assistance by reason of
29.22 immigration status and who have incomes equal to or less than 200 percent of federal
29.23 poverty guidelines.

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

29.27 Sec. 47. Minnesota Statutes 2012, section 256L.04, subdivision 12, is amended to read:

29.28 Subd. 12. **Persons in detention.** ~~Beginning January 1, 1999,~~ An applicant or
29.29 enrollee residing in a correctional or detention facility is not eligible for MinnesotaCare,₂
29.30 unless the applicant or enrollee is awaiting disposition of charges. ~~An enrollee residing in~~
29.31 ~~a correctional or detention facility is not eligible at renewal of eligibility under section~~
29.32 ~~256L.05, subdivision 3a.~~

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

30.1 Sec. 48. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision
30.2 to read:

30.3 Subd. 14. **Coordination with medical assistance.** (a) Individuals eligible for
30.4 medical assistance under chapter 256B are not eligible for MinnesotaCare under this
30.5 section.

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

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

30.12 Sec. 49. Minnesota Statutes 2012, section 256L.05, subdivision 1, is amended to read:

30.13 Subdivision 1. **Application assistance and information availability.** (a) Applicants
30.14 may submit applications online, in person, by mail, or by phone in accordance with the
30.15 Affordable Care Act, and by any other means by which medical assistance applications
30.16 may be submitted. Applicants may submit applications through the Minnesota Insurance
30.17 Marketplace or through the MinnesotaCare program. Applications and application
30.18 assistance must be made available at provider offices, local human services agencies,
30.19 school districts, public and private elementary schools in which 25 percent or more of
30.20 the students receive free or reduced price lunches, community health offices, Women,
30.21 Infants and Children (WIC) program sites, Head Start program sites, public housing
30.22 councils, crisis nurseries, child care centers, early childhood education and preschool
30.23 program sites, legal aid offices, and libraries, and at any other locations at which medical
30.24 assistance applications must be made available. These sites may accept applications and
30.25 forward the forms to the commissioner or local county human services agencies that
30.26 choose to participate as an enrollment site. Otherwise, applicants may apply directly to the
30.27 commissioner or to participating local county human services agencies.

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

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

30.31 Sec. 50. Minnesota Statutes 2012, section 256L.05, subdivision 2, is amended to read:

30.32 Subd. 2. **Commissioner's duties.** The commissioner or county agency shall use
30.33 electronic verification through the Minnesota Insurance Marketplace as the primary

31.1 method of income verification. If there is a discrepancy between reported income
31.2 and electronically verified income, an individual may be required to submit additional
31.3 verification to the extent permitted under the Affordable Care Act. In addition, the
31.4 commissioner shall perform random audits to verify reported income and eligibility. The
31.5 commissioner may execute data sharing arrangements with the Department of Revenue
31.6 and any other governmental agency in order to perform income verification related to
31.7 eligibility and premium payment under the MinnesotaCare program.

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

31.9 Sec. 51. Minnesota Statutes 2012, section 256L.05, subdivision 3, is amended to read:

31.10 Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the
31.11 first day of the month following the month in which eligibility is approved and the first
31.12 premium payment has been received. ~~As provided in section 256B.057, coverage for~~
31.13 ~~newborns is automatic from the date of birth and must be coordinated with other health~~
31.14 ~~coverage. The effective date of coverage for eligible newly adoptive children added to a~~
31.15 ~~family receiving covered health services is the month of placement. The effective date~~
31.16 of coverage for other new members added to the family is the first day of the month
31.17 following the month in which the change is reported. All eligibility criteria must be met
31.18 by the family at the time the new family member is added. The income of the new family
31.19 member is included with the family's modified adjusted gross income and the adjusted
31.20 premium begins in the month the new family member is added.

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

31.23 ~~(e) Benefits are not available until the day following discharge if an enrollee is~~
31.24 ~~hospitalized on the first day of coverage.~~

31.25 ~~(d)~~ (c) Notwithstanding any other law to the contrary, benefits under sections
31.26 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which
31.27 an eligible person may have coverage and the commissioner shall use cost avoidance
31.28 techniques to ensure coordination of any other health coverage for eligible persons. The
31.29 commissioner shall identify eligible persons who may have coverage or benefits under
31.30 other plans of insurance or who become eligible for medical assistance.

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

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

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

32.7 Sec. 52. Minnesota Statutes 2012, section 256L.05, subdivision 3c, is amended to read:

32.8 Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective
32.9 date of coverage shall be the first day of the month following termination from medical
32.10 assistance for families and individuals who are eligible for MinnesotaCare and who
32.11 submitted a written request for retroactive MinnesotaCare coverage with a completed
32.12 application within 30 days of the mailing of notification of termination from medical
32.13 assistance. The applicant must provide all required verifications within 30 days of the
32.14 written request for verification. For retroactive coverage, premiums must be paid in full
32.15 for any retroactive month, current month, and next month within 30 days of the premium
32.16 billing. ~~General assistance medical care recipients may qualify for retroactive coverage~~
32.17 ~~under this subdivision at six-month renewal.~~ This subdivision does not apply, and shall not
32.18 be implemented by the commissioner, once eligibility determination for MinnesotaCare is
32.19 conducted by the Minnesota Insurance Marketplace eligibility determination system.

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

32.21 Sec. 53. Minnesota Statutes 2012, section 256L.06, subdivision 3, is amended to read:

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

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

32.32 (c) Premiums are calculated on a calendar month basis and may be paid on a
32.33 monthly, quarterly, or semiannual basis, with the first payment due upon notice from the

33.1 commissioner of the premium amount required. The commissioner shall inform applicants
33.2 and enrollees of these premium payment options. Premium payment is required before
33.3 enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments
33.4 received before noon are credited the same day. Premium payments received after noon
33.5 are credited on the next working day.

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

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

33.20 Sec. 54. Minnesota Statutes 2012, section 256L.07, subdivision 1, is amended to read:

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

33.28 Parents Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1,
33.29 and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose
33.30 income increases above ~~275~~ 200 percent of the federal poverty guidelines, are no longer
33.31 eligible for the program and shall be disenrolled by the commissioner. ~~Beginning January~~
33.32 ~~1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision~~
33.33 ~~7, whose income increases above 200 percent of the federal poverty guidelines or 250~~
33.34 ~~percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for~~
33.35 ~~the program and shall be disenrolled by the commissioner. For persons disenrolled under~~

34.1 this subdivision, MinnesotaCare coverage terminates the last day of the calendar month
34.2 following the month in which the commissioner determines that the income of a family or
34.3 individual exceeds program income limits.

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

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

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

34.13 Sec. 55. Minnesota Statutes 2012, section 256L.07, subdivision 2, is amended to read:

34.14 Subd. 2. **Must not have access to employer-subsidized minimum essential**
34.15 **coverage.** (a) To be eligible, a family or individual must not have access to subsidized
34.16 health coverage through an employer and must not have had access to employer-subsidized
34.17 coverage through a current employer for 18 months prior to application or reapplication.
34.18 A family or individual whose employer-subsidized coverage is lost due to an employer
34.19 terminating health care coverage as an employee benefit during the previous 18 months is
34.20 not eligible that is affordable and provides minimum value as defined in Code of Federal
34.21 Regulations, title 26, section 1.36B-2.

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

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

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

35.4 Sec. 56. Minnesota Statutes 2012, section 256L.07, subdivision 3, is amended to read:

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

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

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

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

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

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

35.19 (v) ~~vision coverage;~~

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

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

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

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

35.31 (e) (b) For purposes of this subdivision, an applicant or enrollee who is entitled to
35.32 Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social
35.33 Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered
35.34 to have minimum essential health coverage. An applicant or enrollee who is entitled to

36.1 premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage
36.2 to establish eligibility for MinnesotaCare.

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

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

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

36.12 Sec. 57. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

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

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

36.21 Sec. 58. Minnesota Statutes 2012, section 256L.11, subdivision 1, is amended to read:

36.22 Subdivision 1. **Medical assistance rate to be used.** ~~(a) Payment to providers~~
36.23 ~~under sections 256L.01 to 256L.11 this chapter shall be at the same rates and conditions~~
36.24 ~~established for medical assistance, except as provided in subdivisions 2 to 6 this section.~~

36.25 ~~(b) Effective for services provided on or after July 1, 2009, total payments for basic~~
36.26 ~~care services shall be reduced by three percent, in accordance with section 256B.766.~~
36.27 ~~Payments made to managed care and county-based purchasing plans shall be reduced for~~
36.28 ~~services provided on or after October 1, 2009, to reflect this reduction.~~

36.29 ~~(c) Effective for services provided on or after July 1, 2009, payment rates for~~
36.30 ~~physician and professional services shall be reduced as described under section 256B.76,~~
36.31 ~~subdivision 1, paragraph (c). Payments made to managed care and county-based~~
36.32 ~~purchasing plans shall be reduced for services provided on or after October 1, 2009,~~
36.33 ~~to reflect this reduction.~~

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

37.2 Sec. 59. Minnesota Statutes 2012, section 256L.11, subdivision 3, is amended to read:

37.3 Subd. 3. **Inpatient hospital services.** Inpatient hospital services provided under
37.4 section 256L.03, subdivision 3, shall be ~~paid for as provided in subdivisions 4 to 6~~ at the
37.5 medical assistance rate.

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

37.7 Sec. 60. Minnesota Statutes 2012, section 256L.12, subdivision 1, is amended to read:

37.8 Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of
37.9 human services shall select vendors of medical care who can provide the most economical
37.10 care consistent with high medical standards and shall, where possible, contract with
37.11 organizations on a prepaid capitation basis to provide these services. The commissioner
37.12 shall consider proposals by counties and vendors for managed care plans and managed
37.13 care-like entities as defined by the final regulation implementing section 1331 of the
37.14 Affordable Care Act regarding basic health plans, which may include: prepaid capitation
37.15 programs, competitive bidding programs, or other vendor payment mechanisms designed
37.16 to provide services in an economical manner or to control utilization, with safeguards to
37.17 ensure that necessary services are provided.

37.18 Sec. 61. **[256L.121] SERVICE DELIVERY.**

37.19 Subdivision 1. **Competitive process.** The commissioner of human services shall
37.20 establish a competitive process for entering into contracts with participating entities for
37.21 the offering of standard health plans through MinnesotaCare. Coverage through standard
37.22 health plans must be available to enrollees beginning January 1, 2015. Each standard
37.23 health plan must cover the health services listed in and meet the requirements of section
37.24 256L.03. The competitive process must meet the requirements of section 1331 of the
37.25 Affordable Care Act and be designed to ensure enrollee access to high-quality health care
37.26 coverage options. The commissioner, to the extent feasible, shall seek to ensure that
37.27 enrollees have a choice of coverage from more than one participating entity within a
37.28 geographic area. In counties that were part of a county-based purchasing plan on January
37.29 1, 2013, the commissioner shall use the medical assistance competitive procurement
37.30 process under section 256B.69, subdivisions 1 to 32, under which selection of entities is
37.31 based on criteria related to provider network access, coordination of health care with other
37.32 local services, alignment with local public health goals, and other factors.

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

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

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

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

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

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

38.16 (3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and
38.17 256B.694, when contracting with MinnesotaCare participating entities;

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

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

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

38.28 Sec. 62. Minnesota Statutes 2012, section 256L.15, subdivision 1, is amended to read:

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

38.31 ~~(b) Pregnant women and children under age two are exempt from the provisions~~
38.32 ~~of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment~~
38.33 ~~for failure to pay premiums. For pregnant women, this exemption continues until the~~
38.34 ~~first day of the month following the 60th day postpartum. Women who remain enrolled~~
38.35 ~~during pregnancy or the postpartum period, despite nonpayment of premiums, shall be~~

39.1 ~~disenrolled on the first of the month following the 60th day postpartum for the penalty~~
39.2 ~~period that otherwise applies under section 256L.06, unless they begin paying premiums.~~

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

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

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

39.17 Sec. 63. Minnesota Statutes 2012, section 256L.15, subdivision 2, is amended to read:

39.18 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
39.19 commissioner shall establish a sliding fee scale to determine the percentage of monthly
39.20 ~~gross~~ individual or family income that households at different income levels must pay to
39.21 obtain coverage through the MinnesotaCare program. The sliding fee scale must be based
39.22 on the enrollee's monthly ~~gross~~ individual or family income. ~~The sliding fee scale must~~
39.23 ~~contain separate tables based on enrollment of one, two, or three or more persons. Until~~
39.24 ~~June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross~~
39.25 ~~individual or family income for individuals or families with incomes below the limits for~~
39.26 ~~the medical assistance program for families and children in effect on January 1, 1999, and~~
39.27 ~~proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and~~
39.28 ~~8.8 percent. These percentages are matched to evenly spaced income steps ranging from~~
39.29 ~~the medical assistance income limit for families and children in effect on January 1, 1999,~~
39.30 ~~to 275 percent of the federal poverty guidelines for the applicable family size, up to a~~
39.31 ~~family size of five. The sliding fee scale for a family of five must be used for families of~~
39.32 ~~more than five. The sliding fee scale and percentages are not subject to the provisions of~~
39.33 ~~chapter 14. If a family or individual reports increased income after enrollment, premiums~~
39.34 ~~shall be adjusted at the time the change in income is reported.~~

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

40.11 (e) Beginning ~~July 1, 2009~~ January 1, 2014, MinnesotaCare enrollees shall pay
 40.12 premiums according to the premium scale specified in paragraph (d) ~~(c)~~ with the exception
 40.13 that children 20 years of age and younger in families with income at or below 200 percent
 40.14 of the federal poverty guidelines shall pay no premiums. For purposes of paragraph (d),
 40.15 "minimum" means a monthly premium of \$4.

40.16 ~~(d) (c)~~ The following premium scale is established for individuals and families
 40.17 with gross family incomes of 275 percent of the federal poverty guidelines or less each
 40.18 individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum
46-54%	\$4 or 1.1% of family income, whichever is greater
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-275%	7.2%

<u>Federal Poverty Guideline</u>		<u>Individual Premium</u>
<u>Greater than or Equal to</u>	<u>Less than</u>	<u>Amount</u>
<u>0%</u>	<u>55%</u>	<u>\$4</u>
<u>55%</u>	<u>80%</u>	<u>\$6</u>
<u>80%</u>	<u>90%</u>	<u>\$8</u>
<u>90%</u>	<u>100%</u>	<u>\$10</u>
<u>100%</u>	<u>110%</u>	<u>\$12</u>
<u>110%</u>	<u>120%</u>	<u>\$15</u>
<u>120%</u>	<u>130%</u>	<u>\$18</u>
<u>130%</u>	<u>140%</u>	<u>\$21</u>

41.1	<u>140%</u>	<u>150%</u>	<u>\$25</u>
41.2	<u>150%</u>	<u>160%</u>	<u>\$29</u>
41.3	<u>160%</u>	<u>170%</u>	<u>\$33</u>
41.4	<u>170%</u>	<u>180%</u>	<u>\$38</u>
41.5	<u>180%</u>	<u>190%</u>	<u>\$43</u>
41.6	<u>190%</u>		<u>\$50</u>

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

41.10 Sec. 64. **DETERMINATION OF FUNDING ADEQUACY FOR**
 41.11 **MINNESOTACARE.**

41.12 The commissioners of revenue and management and budget, in consultation with
 41.13 the commissioner of human services, shall conduct an assessment of health care taxes,
 41.14 including the gross premiums tax, the provider tax, and Medicaid surcharges, and their
 41.15 relationship to the long-term solvency of the health care access fund, as part of the state
 41.16 revenue and expenditure forecast in November 2013. The commissioners shall determine
 41.17 the amount of state funding that will be required after December 31, 2019, in addition
 41.18 to the federal payments made available under section 1331 of the Affordable Care Act,
 41.19 for the MinnesotaCare program. The commissioners shall evaluate the stability and
 41.20 likelihood of long-term federal funding for the MinnesotaCare program under section
 41.21 1331. The commissioners shall report the results of this assessment to the chairs and
 41.22 ranking minority members of the legislative committees with jurisdiction over human
 41.23 services, finances, and taxes by January 15, 2014, along with recommendations for
 41.24 changes to state revenue for the health care access fund, if state funding continues to
 41.25 be required beyond December 31, 2019.

41.26 Sec. 65. **STATE-BASED RISK ADJUSTMENT SYSTEM ASSESSMENT.**

41.27 (a) Notwithstanding Minnesota Rules, chapter 4653, the commissioner of health,
 41.28 as part of the commissioner's responsibilities under Minnesota Statutes, section 62U.04,
 41.29 subdivision 4, paragraph (b), shall collect from health carriers in the individual and
 41.30 small group health insurance market, beginning on January 1, 2014, for service dates
 41.31 beginning October 1, 2013, through December 31, 2014, all data required for conducting
 41.32 risk adjustment with standard risk adjusters such as the Adjusted Clinical Groups or the
 41.33 Hierarchical Condition Category System, including, but not limited to:

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

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

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

42.5 (4) additional identified demographic data necessary to link individuals' data across
42.6 health carriers and insurance affordability programs with 95 percent accuracy. The
42.7 commissioner shall not collect more than the last four digits of an individual's Social
42.8 Security number.

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

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

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

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

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

42.21 (c) For purposes of paragraph (b), the commissioner of health shall have the
42.22 authority to use identified data to validate and audit a statistically valid sample of data for
42.23 each health carrier in the individual and small group health insurance market.

42.24 (d) If the assessment conducted in paragraph (b) finds that the data collected
42.25 under Minnesota Statutes, section 62U.04, subdivision 4, are sufficient for developing
42.26 and operating a state alternative risk adjustment methodology consistent with applicable
42.27 federal rules, the commissioners of health and human services, in consultation with the
42.28 commissioner of commerce and the Board of MNsure, shall study whether Minnesota-based
42.29 risk adjustment of the individual and small group health insurance market, using either the
42.30 federal risk adjustment model or a state-based alternative, can be more cost-effective and
42.31 perform better than risk adjustment conducted by federal agencies. The study shall assess
42.32 the policies, infrastructure, and resources necessary to satisfy the requirements of Code of
42.33 Federal Regulations, title 45, section 153, subpart D. The study shall also evaluate the
42.34 extent to which Minnesota-based risk adjustment could meet requirements established in
42.35 Code of Federal Regulations, title 45, section 153.330, including:

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

- 43.1 (2) linking risk factors to daily clinical practices and that which is clinically
43.2 meaningful to providers;
- 43.3 (3) encouraging favorable behavior among health care market participants and
43.4 discouraging unfavorable behavior;
- 43.5 (4) whether risk adjustment factors are relatively easy for stakeholders to understand
43.6 and participate in;
- 43.7 (5) providing stable risk scores over time and across health plan products;
- 43.8 (6) minimizing administrative costs;
- 43.9 (7) accounting for risk selection across metal levels;
- 43.10 (8) aligning each of the elements of the methodology; and
- 43.11 (9) can be conducted at per-member cost equal to or lower than the projected cost of
43.12 the federal risk adjustment model.
- 43.13 (e) In conducting the study described in paragraph (d), the commissioner of health
43.14 shall contract with entities that do not have an economic interest in the outcome of
43.15 Minnesota-based risk adjustment, but have demonstrated expertise in actuarial science
43.16 or health economics and demonstrated experience with designing and implementing risk
43.17 adjustment models. The commissioner of human services shall evaluate opportunities
43.18 to maximize federal funding under section 1331 of the Affordable Care Act. The
43.19 commissioner of human services shall make recommendations on risk adjustment
43.20 strategies to maximize federal funding to the state of Minnesota.
- 43.21 (f) The commissioner of health shall submit an interim report to the legislature by
43.22 March 15, 2014, with preliminary findings from the assessment conducted in paragraph
43.23 (b). The interim report shall include legislative recommendations for any necessary
43.24 changes to Minnesota Statutes, section 62Q.03. The commissioners of health and human
43.25 services shall submit a final report to the legislature by October 1, 2015. The final report
43.26 must include findings from the overall assessment conducted under paragraph (e), and a
43.27 recommendation on whether to conduct state-based risk adjustment.
- 43.28 (g) The Board of MNsure shall apply for federal funding under section 1311 or
43.29 1321 of the Affordable Care Act, to fund the work under paragraphs (a), (b), (d), and (e).
43.30 Federal funding awarded to MNsure for this purpose is approved and appropriated for
43.31 this purpose. The commissioners of health and human services may only proceed with
43.32 activities under paragraphs (a) to (e) if funding has been made available for this purpose.
- 43.33 (h) For purposes of this section, the Board of MNsure means the board established
43.34 under Minnesota Statutes, section 62V.03, and the Affordable Care Act has the meaning
43.35 given in Minnesota Statutes, section 256B.02, subdivision 17.

45.1 successor manuals or question and answer documents published by the United States
45.2 Department of Health and Human Services, Centers for Medicare and Medicaid Services,
45.3 to replace or supplement the current version of the manual or document.

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

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

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

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

45.11 (4) all quarterly assessments must have an assessment reference date (ARD) within
45.12 92 days of the ARD of the previous assessment.

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

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

45.19 (2) a nursing facility level of care determination as provided for under section
45.20 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment
45.21 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
45.22 managed care organization under contract with the Department of Human Services.

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

45.24 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**
45.25 **REPORT AND STUDY REQUIRED.**

45.26 Subdivision 1. Report requirements. The commissioners of health and human
45.27 services, with the cooperation of counties and in consultation with stakeholders, including
45.28 persons who need or are using long-term care services and supports, lead agencies,
45.29 regional entities, senior, disability, and mental health organization representatives, service
45.30 providers, and community members shall prepare a report to the legislature by August 15,
45.31 2013, and biennially thereafter, regarding the status of the full range of long-term care
45.32 services and supports for the elderly and children and adults with disabilities and mental
45.33 illnesses in Minnesota. The report shall address:

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

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

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

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

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

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

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

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

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

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

46.25 (b) City, county, and state agencies employing social workers and staff who are
46.26 designated to perform mandated duties under sections 256.975, subdivisions 7 to 7c and
46.27 256.01, subdivision 24, are not required to employ licensed social workers.

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

46.29 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision
46.30 2, the commissioner of human services shall carry out the specific duties in paragraphs (a)
46.31 through ~~(ee)~~ (dd):

46.32 (a) Administer and supervise all forms of public assistance provided for by state law
46.33 and other welfare activities or services as are vested in the commissioner. Administration
46.34 and supervision of human services activities or services includes, but is not limited to,

47.1 assuring timely and accurate distribution of benefits, completeness of service, and quality
47.2 program management. In addition to administering and supervising human services
47.3 activities vested by law in the department, the commissioner shall have the authority to:

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

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

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

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

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

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

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

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

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

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

48.6 (e) Assist and actively cooperate with other departments, agencies and institutions,
48.7 local, state, and federal, by performing services in conformity with the purposes of Laws
48.8 1939, chapter 431.

48.9 (f) Act as the agent of and cooperate with the federal government in matters of
48.10 mutual concern relative to and in conformity with the provisions of Laws 1939, chapter
48.11 431, including the administration of any federal funds granted to the state to aid in the
48.12 performance of any functions of the commissioner as specified in Laws 1939, chapter 431,
48.13 and including the promulgation of rules making uniformly available medical care benefits
48.14 to all recipients of public assistance, at such times as the federal government increases its
48.15 participation in assistance expenditures for medical care to recipients of public assistance,
48.16 the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

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

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

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

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

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

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

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

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

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

49.27 (1) one-half of the total amount of the disallowance shall be borne by the county
49.28 boards responsible for administering the programs. For the medical assistance and the
49.29 AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be
49.30 shared by each county board in the same proportion as that county's expenditures for the
49.31 sanctioned program are to the total of all counties' expenditures for the AFDC program
49.32 formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the
49.33 food stamp program, sanctions shall be shared by each county board, with 50 percent of
49.34 the sanction being distributed to each county in the same proportion as that county's
49.35 administrative costs for food stamps are to the total of all food stamp administrative costs
49.36 for all counties, and 50 percent of the sanctions being distributed to each county in the

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

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

50.13 (o) Develop and implement special projects that maximize reimbursements and
50.14 result in the recovery of money to the state. For the purpose of recovering state money,
50.15 the commissioner may enter into contracts with third parties. Any recoveries that result
50.16 from projects or contracts entered into under this paragraph shall be deposited in the
50.17 state treasury and credited to a special account until the balance in the account reaches
50.18 \$1,000,000. When the balance in the account exceeds \$1,000,000, the excess shall be
50.19 transferred and credited to the general fund. All money in the account is appropriated to
50.20 the commissioner for the purposes of this paragraph.

50.21 (p) Have the authority to make direct payments to facilities providing shelter
50.22 to women and their children according to section 256D.05, subdivision 3. Upon
50.23 the written request of a shelter facility that has been denied payments under section
50.24 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make
50.25 a determination within 30 days of the request for review regarding issuance of direct
50.26 payments to the shelter facility. Failure to act within 30 days shall be considered a
50.27 determination not to issue direct payments.

50.28 (q) Have the authority to establish and enforce the following county reporting
50.29 requirements:

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

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

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

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

51.12 (4) a county board that submits reports that are late, illegible, incomplete, or not
51.13 in the required format for two out of three consecutive reporting periods is considered
51.14 noncompliant. When a county board is found to be noncompliant, the commissioner
51.15 shall notify the county board of the reason the county board is considered noncompliant
51.16 and request that the county board develop a corrective action plan stating how the
51.17 county board plans to correct the problem. The corrective action plan must be submitted
51.18 to the commissioner within 45 days after the date the county board received notice
51.19 of noncompliance;

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

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

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

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

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

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

52.10 (u) Have the authority to administer a drug rebate program for drugs purchased
52.11 pursuant to the prescription drug program established under section 256.955 after the
52.12 beneficiary's satisfaction of any deductible established in the program. The commissioner
52.13 shall require a rebate agreement from all manufacturers of covered drugs as defined in
52.14 section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on
52.15 or after July 1, 2002, must include rebates for individuals covered under the prescription
52.16 drug program who are under 65 years of age. For each drug, the amount of the rebate shall
52.17 be equal to the rebate as defined for purposes of the federal rebate program in United
52.18 States Code, title 42, section 1396r-8. The manufacturers must provide full payment
52.19 within 30 days of receipt of the state invoice for the rebate within the terms and conditions
52.20 used for the federal rebate program established pursuant to section 1927 of title XIX of
52.21 the Social Security Act. The manufacturers must provide the commissioner with any
52.22 information necessary to verify the rebate determined per drug. The rebate program shall
52.23 utilize the terms and conditions used for the federal rebate program established pursuant to
52.24 section 1927 of title XIX of the Social Security Act.

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

52.31 (w) Have the authority to administer a supplemental drug rebate program for drugs
52.32 purchased under the medical assistance program. The commissioner may enter into
52.33 supplemental rebate contracts with pharmaceutical manufacturers and may require prior
52.34 authorization for drugs that are from manufacturers that have not signed a supplemental
52.35 rebate contract. Prior authorization of drugs shall be subject to the provisions of section
52.36 256B.0625, subdivision 13.

53.1 (x) Operate the department's communication systems account established in Laws
53.2 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared
53.3 communication costs necessary for the operation of the programs the commissioner
53.4 supervises. A communications account may also be established for each regional
53.5 treatment center which operates communications systems. Each account must be used
53.6 to manage shared communication costs necessary for the operations of the programs the
53.7 commissioner supervises. The commissioner may distribute the costs of operating and
53.8 maintaining communication systems to participants in a manner that reflects actual usage.
53.9 Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and
53.10 other costs as determined by the commissioner. Nonprofit organizations and state, county,
53.11 and local government agencies involved in the operation of programs the commissioner
53.12 supervises may participate in the use of the department's communications technology and
53.13 share in the cost of operation. The commissioner may accept on behalf of the state any
53.14 gift, bequest, devise or personal property of any kind, or money tendered to the state for
53.15 any lawful purpose pertaining to the communication activities of the department. Any
53.16 money received for this purpose must be deposited in the department's communication
53.17 systems accounts. Money collected by the commissioner for the use of communication
53.18 systems must be deposited in the state communication systems account and is appropriated
53.19 to the commissioner for purposes of this section.

53.20 (y) Receive any federal matching money that is made available through the medical
53.21 assistance program for the consumer satisfaction survey. Any federal money received for
53.22 the survey is appropriated to the commissioner for this purpose. The commissioner may
53.23 expend the federal money received for the consumer satisfaction survey in either year of
53.24 the biennium.

53.25 (z) Designate community information and referral call centers and incorporate
53.26 cost reimbursement claims from the designated community information and referral
53.27 call centers into the federal cost reimbursement claiming processes of the department
53.28 according to federal law, rule, and regulations. Existing information and referral centers
53.29 provided by Greater Twin Cities United Way or existing call centers for which Greater
53.30 Twin Cities United Way has legal authority to represent, shall be included in these
53.31 designations upon review by the commissioner and assurance that these services are
53.32 accredited and in compliance with national standards. Any reimbursement is appropriated
53.33 to the commissioner and all designated information and referral centers shall receive
53.34 payments according to normal department schedules established by the commissioner
53.35 upon final approval of allocation methodologies from the United States Department of
53.36 Health and Human Services Division of Cost Allocation or other appropriate authorities.

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

54.4 (bb) Authorize the method of payment to or from the department as part of the
54.5 human services programs administered by the department. This authorization includes the
54.6 receipt or disbursement of funds held by the department in a fiduciary capacity as part of
54.7 the human services programs administered by the department.

54.8 (cc) Have the authority to administer a drug rebate program for drugs purchased for
54.9 persons eligible for general assistance medical care under section 256D.03, subdivision 3.
54.10 For manufacturers that agree to participate in the general assistance medical care rebate
54.11 program, the commissioner shall enter into a rebate agreement for covered drugs as
54.12 defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the
54.13 rebate shall be equal to the rebate as defined for purposes of the federal rebate program in
54.14 United States Code, title 42, section 1396r-8. The manufacturers must provide payment
54.15 within the terms and conditions used for the federal rebate program established under
54.16 section 1927 of title XIX of the Social Security Act. The rebate program shall utilize
54.17 the terms and conditions used for the federal rebate program established under section
54.18 1927 of title XIX of the Social Security Act.

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

54.21 (1) are covered under the medical assistance program as described in section
54.22 256B.0625, subdivisions 13 and 13d; and

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

54.25 Prescription drug coverage under general assistance medical care shall conform to
54.26 coverage under the medical assistance program according to section 256B.0625,
54.27 subdivisions 13 to 13g.

54.28 The rebate revenues collected under the drug rebate program are deposited in the
54.29 general fund.

54.30 (dd) Designate the agencies that operate the Senior LinkAge Line under section
54.31 256.975, subdivision 7, and the Disability Linkage Line under subdivision 24 as the state
54.32 of Minnesota Aging and the Disability Resource Centers under United States Code, title
54.33 42, section 3001, the Older Americans Act Amendments of 2006, and incorporate cost
54.34 reimbursement claims from the designated centers into the federal cost reimbursement
54.35 claiming processes of the department according to federal law, rule, and regulations. Any
54.36 reimbursement must be appropriated to the commissioner and treated consistent with

55.1 section 256.011. All Aging and Disability Resource Center designated agencies shall
55.2 receive payments of grant funding that supports the activity and generates the federal
55.3 financial participation according to Board on Aging administrative granting mechanisms.

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

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

- 55.12 (1) deliver information and assistance based on national and state standards;
- 55.13 (2) provide information about state and federal eligibility requirements, benefits,
55.14 and service options;
- 55.15 (3) provide benefits and options counseling;
- 55.16 (4) make referrals to appropriate support entities;
- 55.17 (5) educate people on their options so they can make well-informed choices and link
55.18 them to quality profiles;
- 55.19 (6) help support the timely resolution of service access and benefit issues;
- 55.20 (7) inform people of their long-term community services and supports;
- 55.21 (8) provide necessary resources and supports that can lead to employment and
55.22 increased economic stability of people with disabilities; and
- 55.23 (9) serve as the technical assistance and help center for the Web-based tool,
55.24 Minnesota's Disability Benefits 101.org.

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

55.26 Subd. 7. **Consumer information and assistance and long-term care options**
55.27 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
55.28 statewide service to aid older Minnesotans and their families in making informed choices
55.29 about long-term care options and health care benefits. Language services to persons
55.30 with limited English language skills may be made available. The service, known as
55.31 Senior LinkAge Line, shall serve older adults as the designated Aging and Disability
55.32 Resource Center under United States Code, title 42, section 3001, the Older Americans
55.33 Act Amendments of 2006 in partnership with the Disability LinkAge Line under section
55.34 256.01, subdivision 24, and must be available during business hours through a statewide

56.1 toll-free number and ~~must also be available through~~ the Internet. The Minnesota Board
56.2 on Aging shall consult with, and when appropriate work through, the area agencies on
56.3 aging counties, and other entities that serve aging and disabled populations of all ages,
56.4 to provide and maintain the telephone infrastructure and related support for the Aging
56.5 and Disability Resource Center partners which agree by memorandum to access the
56.6 infrastructure, including the designated providers of the Senior LinkAge Line and the
56.7 Disability Linkage Line.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

57.12 ~~(9)~~ (10) incorporate information about the availability of housing options, as well
57.13 as registered housing with services and consumer rights within the MinnesotaHelp.info
57.14 network long-term care database to facilitate consumer comparison of services and costs
57.15 among housing with services establishments and with other in-home services and to
57.16 support financial self-sufficiency as long as possible. Housing with services establishments
57.17 and their arranged home care providers shall provide information that will facilitate price
57.18 comparisons, including delineation of charges for rent and for services available. The
57.19 commissioners of health and human services shall align the data elements required by
57.20 section 144G.06, the Uniform Consumer Information Guide, and this section to provide
57.21 consumers standardized information and ease of comparison of long-term care options.
57.22 The commissioner of human services shall provide the data to the Minnesota Board on
57.23 Aging for inclusion in the MinnesotaHelp.info network long-term care database;

57.24 ~~(10)~~ (11) provide long-term care options counseling. Long-term care options
57.25 counselors shall:

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

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

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

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

58.5 ~~(11)~~ (12) using risk management and support planning protocols, provide long-term
58.6 care options counseling to current residents of nursing homes deemed appropriate for
58.7 discharge by the commissioner and older adults who request service after consultation
58.8 with the Senior LinkAge Line under clause (12). ~~In order to meet this requirement, The~~
58.9 Senior LinkAge Line shall also receive referrals from the residents or staff of nursing
58.10 homes. The Senior LinkAge Line shall identify and contact residents deemed appropriate
58.11 for discharge by developing targeting criteria in consultation with the commissioner who
58.12 shall provide designated Senior LinkAge Line contact centers with a list of nursing
58.13 home residents that meet the criteria as being appropriate for discharge planning via a
58.14 secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a
58.15 preference to receive long-term care options counseling, with initial assessment, review of
58.16 risk factors, independent living support consultation, or and, if appropriate, a referral to:

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

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

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

58.23 ~~(12)~~ (13) develop referral protocols and processes that will assist certified health
58.24 care homes and hospitals to identify at-risk older adults and determine when to refer these
58.25 individuals to the Senior LinkAge Line for long-term care options counseling under this
58.26 section. The commissioner is directed to work with the commissioner of health to develop
58.27 protocols that would comply with the health care home designation criteria and protocols
58.28 available at the time of hospital discharge. The commissioner shall keep a record of the
58.29 number of people who choose long-term care options counseling as a result of this section.

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

58.32 Subd. 7a. **Preadmission screening activities related to nursing facility**
58.33 **admissions.** (a) All individuals seeking admission to Medicaid certified nursing facilities,
58.34 including certified boarding care facilities, must be screened prior to admission regardless
58.35 of income, assets, or funding sources for nursing facility care, except as described in

59.1 subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the
59.2 need for nursing facility level of care as described in section 256B.0911, subdivision
59.3 4e, and to complete activities required under federal law related to mental illness and
59.4 developmental disability as outlined in paragraph (b).

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

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

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

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

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

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

59.22 (ii) a qualified developmental disability professional, for persons with a primary or
59.23 secondary diagnosis of developmental disability. For purposes of this requirement, a
59.24 qualified developmental disability professional must meet the standards for a qualified
59.25 developmental disability professional under Code of Federal Regulations, title 42, section
59.26 483.430.

59.27 (d) The local county mental health authority or the state developmental disability
59.28 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
59.29 nursing facility if the individual does not meet the nursing facility level of care criteria or
59.30 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
59.31 purposes of this section, "specialized services" for a person with developmental disability
59.32 means active treatment as that term is defined under Code of Federal Regulations, title
59.33 42, section 483.440(a)(1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

60.28 (1) a person is admitted from the community to a certified nursing or certified
60.29 boarding care facility during Senior LinkAge Line nonworking hours;

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

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

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

61.3 (5) the Senior LinkAge Line is contacted on the first working day following the
61.4 emergency admission.

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

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

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

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

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

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

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

61.30 (3) the person may be exempt from screening requirements as outlined in subdivision
61.31 7b, but will need transitional assistance after admission or in-person follow-along after
61.32 a return home.

61.33 (b) Individuals under 65 years of age who are admitted to nursing facilities with
61.34 only a telephone screening must receive a face-to-face assessment from the long-term
61.35 care consultation team member of the county in which the facility is located or from the

62.1 recipient's county case manager within 40 calendar days of admission as described in
62.2 section 256B.0911, subdivision 4d, paragraph (c).

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

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

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

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

62.11 **Subd. 7d. Payment for preadmission screening.** Funding for preadmission
62.12 screening shall be provided to the Minnesota Board on Aging by the Department of
62.13 Human Services to cover screener salaries and expenses to provide the services described
62.14 in subdivisions 7a to 7c. The Minnesota Board on Aging shall employ, or contract with
62.15 other agencies to employ, within the limits of available funding, sufficient personnel to
62.16 provide preadmission screening and level of care determination services and shall seek to
62.17 maximize federal funding for the service as provided under section 256.01, subdivision
62.18 2, paragraph (dd).

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

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

62.22 **Subd. 3a. Priority for other grants.** The commissioner of health shall give priority
62.23 to a grantee selected under subdivision 3 when awarding technology-related grants, if the
62.24 grantee is using technology as part of the proposal unless that priority conflicts with
62.25 existing state or federal guidance related to grant awards by the Department of Health.
62.26 The commissioner of transportation shall give priority to a grantee under subdivision 3
62.27 when distributing transportation-related funds to create transportation options for older
62.28 adults unless that preference conflicts with existing state or federal guidance related to
62.29 grant awards by the Department of Transportation.

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

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

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

63.5 Subd. 5. **Grant preference.** The commissioner of human services shall give
63.6 preference when awarding grants under this section to areas where nursing facility
63.7 closures have occurred or are occurring or areas with service needs identified by section
63.8 144A.351. The commissioner may award grants to the extent grant funds are available
63.9 and to the extent applications are approved by the commissioner. Denial of approval of an
63.10 application in one year does not preclude submission of an application in a subsequent
63.11 year. The maximum grant amount is limited to \$750,000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

65.7 ~~(7)~~ (6) determination of home and community-based waiver and other service
65.8 eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level
65.9 of care determination for individuals who need an institutional level of care as determined
65.10 under section 256B.0911, subdivision 4a, ~~paragraph (d)~~ 4e, based on assessment and
65.11 community support plan development, appropriate referrals to obtain necessary diagnostic
65.12 information, and including an eligibility determination for consumer-directed community
65.13 supports;

65.14 ~~(8)~~ (7) providing recommendations for institutional placement when there are no
65.15 cost-effective community services available;

65.16 ~~(9)~~ (8) providing access to assistance to transition people back to community settings
65.17 after institutional admission; and

65.18 ~~(10)~~ (9) providing information about competitive employment, with or without
65.19 supports, for school-age youth and working-age adults and referrals to the Disability
65.20 Linkage Line and Disability Benefits 101 to ensure that an informed choice about
65.21 competitive employment can be made. For the purposes of this subdivision, "competitive
65.22 employment" means work in the competitive labor market that is performed on a full-time
65.23 or part-time basis in an integrated setting, and for which an individual is compensated at or
65.24 above the minimum wage, but not less than the customary wage and level of benefits paid
65.25 by the employer for the same or similar work performed by individuals without disabilities.

65.26 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b,
65.27 2c, and 3a, "long-term care consultation services" also means:

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

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

65.30 (ii) section 256B.0657; or

65.31 (iii) consumer support grants under section 256.476;

65.32 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
65.33 determination of eligibility for case management services available under sections
65.34 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
65.35 9525.0016;

66.1 (3) determination of institutional level of care, home and community-based service
66.2 waiver, and other service eligibility as required under section 256B.092, determination
66.3 of eligibility for family support grants under section 252.32, semi-independent living
66.4 services under section 252.275, and day training and habilitation services under section
66.5 256B.092; and

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

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

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

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

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

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

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

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

67.5 (d) The assessment must be conducted in a face-to-face interview with the person
67.6 being assessed and the person's legal representative, and other individuals as requested by
67.7 the person, who can provide information on the needs, strengths, and preferences of the
67.8 person necessary to develop a community support plan that ensures the person's health and
67.9 safety, but who is not a provider of service or has any financial interest in the provision
67.10 of services. For persons who are to be assessed for elderly waiver customized living
67.11 services under section 256B.0915, with the permission of the person being assessed or
67.12 the person's designated or legal representative, the client's current or proposed provider
67.13 of services may submit a copy of the provider's nursing assessment or written report
67.14 outlining its recommendations regarding the client's care needs. The person conducting
67.15 the assessment will notify the provider of the date by which this information is to be
67.16 submitted. This information shall be provided to the person conducting the assessment
67.17 prior to the assessment.

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

- 67.22 (1) a summary of assessed needs as defined in paragraphs (c) and (d);
67.23 (2) the individual's options and choices to meet identified needs, including all
67.24 available options for case management services and providers;
67.25 (3) identification of health and safety risks and how those risks will be addressed,
67.26 including personal risk management strategies;
67.27 (4) referral information; and
67.28 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

68.15 (3) the need for and purpose of preadmission screening conducted by long-term care
68.16 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
68.17 nursing facility placement. If the individual selects nursing facility placement, the lead
68.18 agency shall forward information needed to complete the level of care determinations and
68.19 screening for developmental disability and mental illness collected during the assessment
68.20 to the long-term care options counselor using forms provided by the commissioner;

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

68.25 (5) information about Minnesota health care programs;

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

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

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

68.33 (9) the person's right to appeal the certified assessor's decision regarding eligibility
68.34 for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and
68.35 (b), and incorporating the decision regarding the need for institutional level of care or the

69.1 lead agency's final decisions regarding public programs eligibility according to section
69.2 256.045, subdivision 3.

69.3 (i) Face-to-face assessment completed as part of eligibility determination for
69.4 the alternative care, elderly waiver, community alternatives for disabled individuals,
69.5 community alternative care, and brain injury waiver programs under sections 256B.0913,
69.6 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60
69.7 calendar days after the date of assessment.

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

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

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

69.23 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified
69.24 nursing facility from a hospital must be screened prior to admission ~~as outlined in~~
69.25 ~~subdivisions 4a through 4e~~ according to the requirements outlined in section 256.975,
69.26 subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required
69.27 under section 256.975, subdivision 7.

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

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

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

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

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

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

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

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

70.26 (j) Funding for preadmission screening follow-up shall be provided to the Disability
70.27 Linkage Line for the under 60 population by the Department of Human Services to
70.28 cover options counseling salaries and expenses to provide the services described in
70.29 subdivisions 7a to 7c. The Disability Linkage Line shall employ, or contract with other
70.30 agencies to employ, within the limits of available funding, sufficient personnel to provide
70.31 preadmission screening follow-up services and shall seek to maximize federal funding for
70.32 the service as provided under section 256.01, subdivision 2, paragraph (dd).

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

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

71.1 Subd. 4e. **Determination of institutional level of care.** The determination of the
71.2 need for nursing facility, hospital, and intermediate care facility levels of care must be
71.3 made according to criteria developed by the commissioner, and in section 256B.092,
71.4 using forms developed by the commissioner. Effective January 1, 2014, for individuals
71.5 age 21 and older, the determination of need for nursing facility level of care shall be
71.6 based on criteria in section 144.0724, subdivision 11. For individuals under age 21, the
71.7 determination of the need for nursing facility level of care must be made according to
71.8 criteria developed by the commissioner until criteria in section 144.0724, subdivision 11,
71.9 becomes effective on or after October 1, 2019.

71.10 Sec. 22. Minnesota Statutes 2012, section 256B.0911, subdivision 6, is amended to read:

71.11 **Subd. 6. Payment for long-term care consultation services.** (a) Until September
71.12 30, 2013, payment for long-term care consultation face-to-face assessment shall be made
71.13 as described in this subdivision.

71.14 (b) The total payment for each county must be paid monthly by certified nursing
71.15 facilities in the county. The monthly amount to be paid by each nursing facility for each
71.16 fiscal year must be determined by dividing the county's annual allocation for long-term
71.17 care consultation services by 12 to determine the monthly payment and allocating the
71.18 monthly payment to each nursing facility based on the number of licensed beds in the
71.19 nursing facility. Payments to counties in which there is no certified nursing facility must be
71.20 made by increasing the payment rate of the two facilities located nearest to the county seat.

71.21 ~~(b)~~ (c) The commissioner shall include the total annual payment determined under
71.22 paragraph (a) for each nursing facility reimbursed under section 256B.431, 256B.434,
71.23 or 256B.441.

71.24 ~~(e)~~ (d) In the event of the layaway, delicensure and decertification, or removal
71.25 from layaway of 25 percent or more of the beds in a facility, the commissioner may
71.26 adjust the per diem payment amount in paragraph ~~(b)~~ (c) and may adjust the monthly
71.27 payment amount in paragraph ~~(a)~~ (b). The effective date of an adjustment made under this
71.28 paragraph shall be on or after the first day of the month following the effective date of the
71.29 layaway, delicensure and decertification, or removal from layaway.

71.30 ~~(d)~~ (e) Payments for long-term care consultation services are available to the county
71.31 or counties to cover staff salaries and expenses to provide the services described in
71.32 subdivision 1a. The county shall employ, or contract with other agencies to employ,
71.33 within the limits of available funding, sufficient personnel to provide long-term care
71.34 consultation services while meeting the state's long-term care outcomes and objectives as
71.35 defined in subdivision 1. The county shall be accountable for meeting local objectives

72.1 as approved by the commissioner in the biennial home and community-based services
72.2 quality assurance plan on a form provided by the commissioner.

72.3 ~~(e)~~ (f) Notwithstanding section 256B.0641, overpayments attributable to payment
72.4 of the screening costs under the medical assistance program may not be recovered from
72.5 a facility.

72.6 ~~(f)~~ (g) The commissioner of human services shall amend the Minnesota medical
72.7 assistance plan to include reimbursement for the local consultation teams.

72.8 ~~(g)~~ (h) Until the alternative payment methodology in paragraph ~~(h)~~ (i) is implemented,
72.9 the county may bill, as case management services, assessments, support planning, and
72.10 follow-along provided to persons determined to be eligible for case management under
72.11 Minnesota health care programs. No individual or family member shall be charged for an
72.12 initial assessment or initial support plan development provided under subdivision 3a or 3b.

72.13 ~~(h)~~ (i) The commissioner shall develop an alternative payment methodology,
72.14 effective on October 1, 2013, for long-term care consultation services that includes
72.15 the funding available under this subdivision, and for assessments authorized under
72.16 sections 256B.092 and 256B.0659. In developing the new payment methodology, the
72.17 commissioner shall consider the maximization of other funding sources, including federal
72.18 administrative reimbursement through federal financial participation funding, for all
72.19 long-term care consultation ~~and preadmission screening~~ activity. The alternative payment
72.20 methodology shall include the use of the appropriate time studies and the state financing
72.21 of nonfederal share as part of the state's medical assistance program.

72.22 Sec. 23. Minnesota Statutes 2012, section 256B.0911, subdivision 7, is amended to read:

72.23 Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance
72.24 reimbursement for nursing facilities shall be authorized for a medical assistance recipient
72.25 only if a preadmission screening has been conducted prior to admission or the county has
72.26 authorized an exemption. Medical assistance reimbursement for nursing facilities shall
72.27 not be provided for any recipient who the local screener has determined does not meet the
72.28 level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or,
72.29 if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus
72.30 Budget Reconciliation Act of 1987 completed unless an admission for a recipient with
72.31 mental illness is approved by the local mental health authority or an admission for a
72.32 recipient with developmental disability is approved by the state developmental disability
72.33 authority.

72.34 (b) The nursing facility must not bill a person who is not a medical assistance
72.35 recipient for resident days that preceded the date of completion of screening activities

73.1 as required under section 256.975, subdivisions ~~4a, 4b, and 4e~~ 7a to 7c. The nursing
73.2 facility must include unreimbursed resident days in the nursing facility resident day totals
73.3 reported to the commissioner.

73.4 Sec. 24. Minnesota Statutes 2012, section 256B.0913, subdivision 4, is amended to read:

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

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

73.8 (1) the person has been determined by a community assessment under section
73.9 256B.0911 to be a person who would require the level of care provided in a nursing
73.10 facility, as determined under section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, but for
73.11 the provision of services under the alternative care program;

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

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

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

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

73.21 (6) except for individuals described in clause (7), the monthly cost of the alternative
73.22 care services funded by the program for this person does not exceed 75 percent of the
73.23 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
73.24 does not prohibit the alternative care client from payment for additional services, but in no
73.25 case may the cost of additional services purchased under this section exceed the difference
73.26 between the client's monthly service limit defined under section 256B.0915, subdivision
73.27 3, and the alternative care program monthly service limit defined in this paragraph. If
73.28 care-related supplies and equipment or environmental modifications and adaptations are or
73.29 will be purchased for an alternative care services recipient, the costs may be prorated on a
73.30 monthly basis for up to 12 consecutive months beginning with the month of purchase.
73.31 If the monthly cost of a recipient's other alternative care services exceeds the monthly
73.32 limit established in this paragraph, the annual cost of the alternative care services shall be
73.33 determined. In this event, the annual cost of alternative care services shall not exceed 12
73.34 times the monthly limit described in this paragraph;

74.1 (7) for individuals assigned a case mix classification A as described under section
74.2 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily
74.3 living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating
74.4 when the dependency score in eating is three or greater as determined by an assessment
74.5 performed under section 256B.0911, the monthly cost of alternative care services funded
74.6 by the program cannot exceed \$593 per month for all new participants enrolled in
74.7 the program on or after July 1, 2011. This monthly limit shall be applied to all other
74.8 participants who meet this criteria at reassessment. This monthly limit shall be increased
74.9 annually as described in section 256B.0915, subdivision 3a, paragraph (a). This monthly
74.10 limit does not prohibit the alternative care client from payment for additional services, but
74.11 in no case may the cost of additional services purchased exceed the difference between the
74.12 client's monthly service limit defined in this clause and the limit described in clause (6)
74.13 for case mix classification A; and

74.14 (8) the person is making timely payments of the assessed monthly fee.
74.15 A person is ineligible if payment of the fee is over 60 days past due, unless the person
74.16 agrees to:

- 74.17 (i) the appointment of a representative payee;
- 74.18 (ii) automatic payment from a financial account;
- 74.19 (iii) the establishment of greater family involvement in the financial management of
74.20 payments; or
- 74.21 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

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

74.26 (b) Alternative care funding under this subdivision is not available for a person who
74.27 is a medical assistance recipient or who would be eligible for medical assistance without a
74.28 spenddown or waiver obligation. A person whose initial application for medical assistance
74.29 and the elderly waiver program is being processed may be served under the alternative care
74.30 program for a period up to 60 days. If the individual is found to be eligible for medical
74.31 assistance, medical assistance must be billed for services payable under the federally
74.32 approved elderly waiver plan and delivered from the date the individual was found eligible
74.33 for the federally approved elderly waiver plan. Notwithstanding this provision, alternative
74.34 care funds may not be used to pay for any service the cost of which: (i) is payable by
74.35 medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to

75.1 pay a medical assistance income spenddown for a person who is eligible to participate in the
75.2 federally approved elderly waiver program under the special income standard provision.

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

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

75.13 Sec. 25. Minnesota Statutes 2012, section 256B.0915, subdivision 5, is amended to read:

75.14 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
75.15 shall receive an initial assessment of strengths, informal supports, and need for services
75.16 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
75.17 client served under the elderly waiver must be conducted at least every 12 months and at
75.18 other times when the case manager determines that there has been significant change in
75.19 the client's functioning. This may include instances where the client is discharged from
75.20 the hospital. There must be a determination that the client requires nursing facility level
75.21 of care as defined in section 256B.0911, subdivision 4a, ~~paragraph (d)~~ 4e, at initial and
75.22 subsequent assessments to initiate and maintain participation in the waiver program.

75.23 (b) Regardless of other assessments identified in section 144.0724, subdivision
75.24 4, as appropriate to determine nursing facility level of care for purposes of medical
75.25 assistance payment for nursing facility services, only face-to-face assessments conducted
75.26 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
75.27 level of care determination will be accepted for purposes of initial and ongoing access to
75.28 waiver service payment.

75.29 Sec. 26. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
75.30 subdivision to read:

75.31 Subd. 1a. Home and community-based services for older adults. (a) The purpose
75.32 of projects selected by the commissioner of human services under this section is to
75.33 make strategic changes in the long-term services and supports system for older adults
75.34 including statewide capacity for local service development and technical assistance, and

76.1 statewide availability of home and community-based services for older adult services,
76.2 caregiver support and respite care services, and other supports in the state of Minnesota.
76.3 These projects are intended to create incentives for new and expanded home and
76.4 community-based services in Minnesota in order to:

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

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

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

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

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

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

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

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

76.21 (9) strengthen programs that use volunteers.

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

76.27 Sec. 27. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
76.28 subdivision to read:

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

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

76.33 (c) "Core home and community-based services provider" means a Faith in Action,
76.34 Living at Home Block Nurse, Congregational Nurse, or similar community-based
76.35 program governed by a board, the majority of whose members reside within the program's

77.1 service area, that organizes and uses volunteers and paid staff to deliver nonmedical
77.2 services intended to assist older adults to identify and manage risks and to maintain their
77.3 community living and integration in the community.

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

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

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

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

77.16 Subd. 1c. **Eldercare development partnerships.** The commissioner of human
77.17 services shall select and contract with eldercare development partnerships sufficient to
77.18 provide statewide availability of service development and technical assistance using a
77.19 request for proposals process. Eldercare development partnerships shall:

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

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

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

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

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

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

77.34 Sec. 29. Minnesota Statutes 2012, section 256B.0917, subdivision 6, is amended to read:

78.1 Subd. 6. **Caregiver support and respite care projects.** (a) The commissioner
78.2 shall establish ~~up to 36~~ projects to expand the respite care network in the state and to
78.3 support caregivers in their responsibilities for care. The purpose of each project shall
78.4 be to availability of caregiver support and respite care services for family and other
78.5 caregivers. The commissioner shall use a request for proposals to select nonprofit entities
78.6 to administer the projects. Projects shall:

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

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

78.10 (3) ~~provide training for caregivers and ensure that support groups are available~~
78.11 ~~in the community.~~

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

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

78.22 (d) ~~The commissioner shall select grantees based on the following criteria:~~

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

78.25 (2) ~~the ability of the proposal to clearly describe how the project~~

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

78.27 (4) identify at-risk caregivers;

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

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

78.34 (b) Projects must clearly describe:

78.35 (1) how they will achieve the their purpose defined in paragraph (b);

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

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

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

79.6 ~~(6) the inclusion in the proposal of the (3) a plan to promote the project in the~~
79.7 ~~designated community, including outreach to persons needing the services.~~

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

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

79.11 (2) recruit and train volunteer providers;

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

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

79.14 ~~(5) (4) advertise the availability of the caregiver support and respite care project; and~~

79.15 ~~(6) (5) purchase equipment to maintain a system of assigning workers to clients.~~

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

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

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

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

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

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

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

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

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

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

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

80.5 Sec. 31. Minnesota Statutes 2012, section 256B.0917, subdivision 13, is amended to
80.6 read:

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

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

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

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

80.17 Sec. 32. Minnesota Statutes 2012, section 256B.439, subdivision 3, is amended to read:

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

80.25 Sec. 33. Minnesota Statutes 2012, section 256B.439, is amended by adding a
80.26 subdivision to read:

80.27 Subd. 3a. **Home and community-based services report card in cooperation with**
80.28 **the commissioner of health.** The commissioner shall work with existing Department
80.29 of Human Services advisory groups to develop recommendations for a home and
80.30 community-based services report card. Health and human services staff that regulate
80.31 home and community-based services as provided in chapter 245D and licensed home care
80.32 as provided in chapter 144A shall be consulted. The advisory groups shall consider the
80.33 requirements from the Minnesota consumer information guide under section 144G.06 as a

81.1 base for development of the home and community-based services report card to compare
81.2 the housing options available to consumers. Other items to be considered by the advisory
81.3 groups in developing recommendations include:

81.4 (1) defining the goals of the report card, including measuring outcomes, providing
81.5 consumer information, and defining vehicle-for-pay performance;

81.6 (2) developing separate measures for programs for the elderly population and for
81.7 persons with disabilities;

81.8 (3) the sources of information needed that are standardized and contain sufficient data;

81.9 (4) the financial support needed for creating and publicizing the housing information
81.10 guide, and ongoing funding for data collection and staffing to monitor, report, and analyze;

81.11 (5) a recognition that home and community-based services settings exist with
81.12 significant variations in size, settings, and services available;

81.13 (6) ensuring that consumer choice and consumer information is retained and valued;

81.14 (7) the applicability of these measures to providers based on payor source, size,
81.15 and population served; and

81.16 (8) dissemination of quality profiles.

81.17 The advisory groups shall discuss whether there are additional funding, resources,
81.18 and research needed. The commissioner shall report recommendations to the chairs and
81.19 ranking minority members of the legislative committees and divisions with jurisdiction
81.20 over health and human services issues by August 1, 2014. The report card shall be
81.21 available on July 1, 2015.

81.22 Sec. 34. Minnesota Statutes 2012, section 256B.439, subdivision 4, is amended to read:

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

81.30 Sec. 35. Minnesota Statutes 2012, section 256B.441, subdivision 13, is amended to read:

81.31 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the
81.32 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
81.33 section 144.122; until September 30, 2013, long-term care consultation fees under
81.34 section 256B.0911, subdivision 6; family advisory council fee under section 144A.33;

82.1 scholarships under section 256B.431, subdivision 36; planned closure rate adjustments
82.2 under section 256B.437; or single bed room incentives under section 256B.431,
82.3 subdivision 42; property taxes and property insurance; and PERA.

82.4 Sec. 36. Minnesota Statutes 2012, section 256B.441, subdivision 53, is amended to read:

82.5 Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner
82.6 shall calculate a payment rate for external fixed costs.

82.7 (a) For a facility licensed as a nursing home, the portion related to section 256.9657
82.8 shall be equal to \$8.86. For a facility licensed as both a nursing home and a boarding care
82.9 home, the portion related to section 256.9657 shall be equal to \$8.86 multiplied by the
82.10 result of its number of nursing home beds divided by its total number of licensed beds.

82.11 (b) The portion related to the licensure fee under section 144.122, paragraph (d),
82.12 shall be the amount of the fee divided by actual resident days.

82.13 (c) The portion related to scholarships shall be determined under section 256B.431,
82.14 subdivision 36.

82.15 (d) Until September 30, 2013, the portion related to long-term care consultation shall
82.16 be determined according to section 256B.0911, subdivision 6.

82.17 (e) The portion related to development and education of resident and family advisory
82.18 councils under section 144A.33 shall be \$5 divided by 365.

82.19 (f) The portion related to planned closure rate adjustments shall be as determined
82.20 under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436.
82.21 Planned closure rate adjustments that take effect before October 1, 2014, shall no longer
82.22 be included in the payment rate for external fixed costs beginning October 1, 2016.
82.23 Planned closure rate adjustments that take effect on or after October 1, 2014, shall no
82.24 longer be included in the payment rate for external fixed costs beginning on October 1 of
82.25 the first year not less than two years after their effective date.

82.26 (g) The portions related to property insurance, real estate taxes, special assessments,
82.27 and payments made in lieu of real estate taxes directly identified or allocated to the nursing
82.28 facility shall be the actual amounts divided by actual resident days.

82.29 (h) The portion related to the Public Employees Retirement Association shall be
82.30 actual costs divided by resident days.

82.31 (i) The single bed room incentives shall be as determined under section 256B.431,
82.32 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
82.33 no longer be included in the payment rate for external fixed costs beginning October 1,
82.34 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no

83.1 longer be included in the payment rate for external fixed costs beginning on October 1 of
83.2 the first year not less than two years after their effective date.

83.3 (j) The payment rate for external fixed costs shall be the sum of the amounts in
83.4 paragraphs (a) to (i).

83.5 Sec. 37. Minnesota Statutes 2012, section 256B.49, subdivision 12, is amended to read:

83.6 Subd. 12. **Informed choice.** Persons who are determined likely to require the level
83.7 of care provided in a nursing facility as determined under section 256B.0911, subdivision
83.8 4e, or a hospital shall be informed of the home and community-based support alternatives
83.9 to the provision of inpatient hospital services or nursing facility services. Each person
83.10 must be given the choice of either institutional or home and community-based services
83.11 using the provisions described in section 256B.77, subdivision 2, paragraph (p).

83.12 Sec. 38. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

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

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

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

84.1 (d) Recipients who are found eligible for home and community-based services under
84.2 this section before their 65th birthday may remain eligible for these services after their
84.3 65th birthday if they continue to meet all other eligibility factors.

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

84.15 Sec. 39. Minnesota Statutes 2012, section 256B.69, subdivision 8, is amended to read:

84.16 Subd. 8. **Preadmission screening waiver.** Except as applicable to the project's
84.17 operation, the provisions of ~~section~~ sections 256.975 and 256B.0911 are waived for the
84.18 purposes of this section for recipients enrolled with demonstration providers or in the
84.19 prepaid medical assistance program for seniors.

84.20 Sec. 40. Minnesota Statutes 2012, section 256I.05, is amended by adding a subdivision
84.21 to read:

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

84.29 Sec. 41. Minnesota Statutes 2012, section 626.557, subdivision 4, is amended to read:

84.30 Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter
84.31 shall immediately make an oral report to the common entry point. The common entry
84.32 point may accept electronic reports submitted through a Web-based reporting system
84.33 established by the commissioner. Use of a telecommunications device for the deaf or other

85.1 similar device shall be considered an oral report. The common entry point may not require
85.2 written reports. To the extent possible, the report must be of sufficient content to identify
85.3 the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment,
85.4 any evidence of previous maltreatment, the name and address of the reporter, the time,
85.5 date, and location of the incident, and any other information that the reporter believes
85.6 might be helpful in investigating the suspected maltreatment. A mandated reporter may
85.7 disclose not public data, as defined in section 13.02, and medical records under sections
85.8 144.291 to 144.298, to the extent necessary to comply with this subdivision.

85.9 (b) A boarding care home that is licensed under sections 144.50 to 144.58 and
85.10 certified under Title 19 of the Social Security Act, a nursing home that is licensed under
85.11 section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a
85.12 hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under
85.13 Code of Federal Regulations, title 42, section 482.66, may submit a report electronically
85.14 to the common entry point instead of submitting an oral report. The report may be a
85.15 duplicate of the initial report the facility submits electronically to the commissioner of
85.16 health to comply with the reporting requirements under Code of Federal Regulations, title
85.17 42, section 483.13. The commissioner of health may modify these reporting requirements
85.18 to include items required under paragraph (a) that are not currently included in the
85.19 electronic reporting form.

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

85.21 Sec. 42. Minnesota Statutes 2012, section 626.557, subdivision 9, is amended to read:

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

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

- 85.30 (1) the time and date of the report;
- 85.31 (2) the name, address, and telephone number of the person reporting;
- 85.32 (3) the time, date, and location of the incident;
- 85.33 (4) the names of the persons involved, including but not limited to, perpetrators,
85.34 alleged victims, and witnesses;
- 85.35 (5) whether there was a risk of imminent danger to the alleged victim;

- 86.1 (6) a description of the suspected maltreatment;
- 86.2 (7) the disability, if any, of the alleged victim;
- 86.3 (8) the relationship of the alleged perpetrator to the alleged victim;
- 86.4 (9) whether a facility was involved and, if so, which agency licenses the facility;
- 86.5 (10) any action taken by the common entry point;
- 86.6 (11) whether law enforcement has been notified;
- 86.7 (12) whether the reporter wishes to receive notification of the initial and final
- 86.8 reports; and
- 86.9 (13) if the report is from a facility with an internal reporting procedure, the name,
- 86.10 mailing address, and telephone number of the person who initiated the report internally.
- 86.11 (c) The common entry point is not required to complete each item on the form prior
- 86.12 to dispatching the report to the appropriate lead investigative agency.
- 86.13 (d) The common entry point shall immediately report to a law enforcement agency
- 86.14 any incident in which there is reason to believe a crime has been committed.
- 86.15 (e) If a report is initially made to a law enforcement agency or a lead investigative
- 86.16 agency, those agencies shall take the report on the appropriate common entry point intake
- 86.17 forms and immediately forward a copy to the common entry point.
- 86.18 (f) The common entry point staff must receive training on how to screen and
- 86.19 dispatch reports efficiently and in accordance with this section.
- 86.20 (g) The commissioner of human services shall maintain a centralized database
- 86.21 for the collection of common entry point data, lead investigative agency data including
- 86.22 maltreatment report disposition, and appeals data. The common entry point shall
- 86.23 have access to the centralized database and must log the reports into the database and
- 86.24 immediately identify and locate prior reports of abuse, neglect, or exploitation.
- 86.25 (h) When appropriate, the common entry point staff must refer calls that do not
- 86.26 allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations
- 86.27 that might resolve the reporter's concerns.
- 86.28 (i) a common entry point must be operated in a manner that enables the
- 86.29 commissioner of human services to:
- 86.30 (1) track critical steps in the reporting, evaluation, referral, response, disposition,
- 86.31 and investigative process to ensure compliance with all requirements for all reports;
- 86.32 (2) maintain data to facilitate the production of aggregate statistical reports for
- 86.33 monitoring patterns of abuse, neglect, or exploitation;
- 86.34 (3) serve as a resource for the evaluation, management, and planning of preventative
- 86.35 and remedial services for vulnerable adults who have been subject to abuse, neglect,
- 86.36 or exploitation;

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

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

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

87.9 Sec. 43. Minnesota Statutes 2012, section 626.557, subdivision 9e, is amended to read:

87.10 Subd. 9e. **Education requirements.** (a) The commissioners of health, human
87.11 services, and public safety shall cooperate in the development of a joint program for
87.12 education of lead investigative agency investigators in the appropriate techniques for
87.13 investigation of complaints of maltreatment. This program must be developed by July
87.14 1, 1996. The program must include but need not be limited to the following areas: (1)
87.15 information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4)
87.16 conclusions based on evidence; (5) interviewing skills, including specialized training to
87.17 interview people with unique needs; (6) report writing; (7) coordination and referral
87.18 to other necessary agencies such as law enforcement and judicial agencies; (8) human
87.19 relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family
87.20 systems and the appropriate methods for interviewing relatives in the course of the
87.21 assessment or investigation; (10) the protective social services that are available to protect
87.22 alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by
87.23 which lead investigative agency investigators and law enforcement workers cooperate in
87.24 conducting assessments and investigations in order to avoid duplication of efforts; and
87.25 (12) data practices laws and procedures, including provisions for sharing data.

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

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

87.32 ~~(e)~~ (d) The commissioner of human services, in coordination with the commissioner
87.33 of public safety shall provide training for the common entry point staff as required in this
87.34 subdivision and the program courses described in this subdivision, at least four times
87.35 per year. At a minimum, the training shall be held twice annually in the seven-county

88.1 metropolitan area and twice annually outside the seven-county metropolitan area. The
88.2 commissioners shall give priority in the program areas cited in paragraph (a) to persons
88.3 currently performing assessments and investigations pursuant to this section.

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

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

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

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

88.17 Sec. 44. **FEDERAL APPROVAL.**

88.18 This article is contingent on federal approval.

88.19 Sec. 45. **REPEALER.**

88.20 (a) Minnesota Statutes 2012, sections 245A.655; and 256B.0917, subdivisions 1, 2,
88.21 3, 4, 5, 7, 8, 9, 10, 11, and 12, are repealed.

88.22 (b) Minnesota Statutes 2012, section 256B.0911, subdivisions 4a, 4b, and 4c, are
88.23 repealed effective October 1, 2013.

88.24 **ARTICLE 3**

88.25 **SAFE AND HEALTHY DEVELOPMENT OF CHILDREN,**
88.26 **YOUTH, AND FAMILIES**

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

88.29 Subd. 19b. **Student parent.** "Student parent" means a person who is:

88.30 (1) under 21 years of age and has a child;

88.31 (2) pursuing a high school or general equivalency diploma;

88.32 (3) residing within a county that has a basic sliding fee waiting list under section
88.33 119B.03, subdivision 4; and

88.34 (4) not an MFIP participant.

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

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

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

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

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

89.9 Subdivision 1. **Factors which must be verified.** (a) The county shall verify the
89.10 following at all initial child care applications using the universal application:

89.11 (1) identity of adults;

89.12 (2) presence of the minor child in the home, if questionable;

89.13 (3) relationship of minor child to the parent, stepparent, legal guardian, eligible
89.14 relative caretaker, or the spouses of any of the foregoing;

89.15 (4) age;

89.16 (5) immigration status, if related to eligibility;

89.17 (6) Social Security number, if given;

89.18 (7) income;

89.19 (8) spousal support and child support payments made to persons outside the
89.20 household;

89.21 (9) residence; and

89.22 (10) inconsistent information, if related to eligibility.

89.23 (b) If a family did not use the universal application or child care addendum to apply
89.24 for child care assistance, the family must complete the universal application or child care
89.25 addendum at its next eligibility redetermination and the county must verify the factors
89.26 listed in paragraph (a) as part of that redetermination. Once a family has completed a
89.27 universal application or child care addendum, the county shall use the redetermination
89.28 form described in paragraph (c) for that family's subsequent redeterminations. Eligibility
89.29 must be redetermined at least every six months. A family is considered to have met the
89.30 eligibility redetermination requirement if a complete redetermination form and all required
89.31 verifications are received within 30 days after the date the form was due. Assistance shall
89.32 be payable retroactively from the redetermination due date. For a family where at least
89.33 one parent is under the age of 21, does not have a high school or general equivalency
89.34 diploma, and is a student in a school district or another similar program that provides or

90.1 arranges for child care, as well as parenting, social services, career and employment
90.2 supports, and academic support to achieve high school graduation, the redetermination of
90.3 eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of
90.4 the student's school year. If a family reports a change in an eligibility factor before the
90.5 family's next regularly scheduled redetermination, the county must recalculate eligibility
90.6 without requiring verification of any eligibility factor that did not change.

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

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

90.11 Sec. 4. Minnesota Statutes 2012, section 119B.03, subdivision 4, is amended to read:

90.12 Subd. 4. **Funding priority.** (a) First priority for child care assistance under the
90.13 basic sliding fee program must be given to eligible non-MFIP families who do not have a
90.14 high school or general equivalency diploma or who need remedial and basic skill courses
90.15 in order to pursue employment or to pursue education leading to employment and who
90.16 need child care assistance to participate in the education program. This includes student
90.17 parents as defined under section 119B.011, subdivision 19b. Within this priority, the
90.18 following subpriorities must be used:

90.19 (1) child care needs of minor parents;

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

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

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

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

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

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

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

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

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

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

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

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

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

91.14 (5) MFIP families who are participating in social services activities under chapter
91.15 256J as required in their employment plan approved according to chapter 256J;

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

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

91.20 (8) families who are participating in the transition year extension under section
91.21 119B.011, subdivision 20a; and

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

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

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

91.25 Subdivision 1. **Subsidy restrictions.** (a) ~~Beginning October 31, 2014~~ Beginning February 3,
91.26 2014, the maximum rate paid for child care assistance in any county or ~~multicounty region~~
91.27 county price cluster under the child care fund shall be the ~~rate for like-care arrangements in~~
91.28 the county effective July 1, 2006, decreased by 2.5 percent greater of the 25th percentile of
91.29 the 2011 child care provider rate survey or the maximum rate effective November 28, 2011.
91.30 The commissioner may: (1) assign a county with no reported provider prices to a similar
91.31 price cluster; and (2) consider county level access when determining final price clusters.

91.32 (b) ~~Biennially, beginning in 2012, the commissioner shall survey rates charged~~
91.33 ~~by child care providers in Minnesota to determine the 75th percentile for like-care~~
91.34 ~~arrangements in counties. When the commissioner determines that, using the~~
91.35 ~~commissioner's established protocol, the number of providers responding to the survey is~~

92.1 ~~too small to determine the 75th percentile rate for like-care arrangements in a county or~~
92.2 ~~multicounty region, the commissioner may establish the 75th percentile maximum rate~~
92.3 ~~based on like-care arrangements in a county, region, or category that the commissioner~~
92.4 ~~deems to be similar.~~

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

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

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

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

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

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

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

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

92.28 (b) The maximum rate paid to legal nonlicensed family child care providers must be
92.29 68 percent of the county maximum hourly rate for licensed family child care providers. In
92.30 counties or county price clusters where the maximum hourly rate for licensed family child
92.31 care providers is higher than the maximum weekly rate for those providers divided by 50,
92.32 the maximum hourly rate that may be paid to legal nonlicensed family child care providers
92.33 is the rate equal to the maximum weekly rate for licensed family child care providers
92.34 divided by 50 and then multiplied by 0.68. The maximum payment to a provider for one

93.1 day of care must not exceed the maximum hourly rate times ten. The maximum payment
93.2 to a provider for one week of care must not exceed the maximum hourly rate times 50.

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

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

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

93.8 Sec. 8. Minnesota Statutes 2012, section 119B.13, subdivision 3a, is amended to read:

93.9 Subd. 3a. **Provider rate differential for accreditation.** A family child care
93.10 provider or child care center shall be paid a 15 percent differential above the maximum
93.11 rate established in subdivision 1, up to the actual provider rate, if the provider or center
93.12 holds a current early childhood development credential or is accredited. For a family
93.13 child care provider, early childhood development credential and accreditation includes
93.14 an individual who has earned a child development associate degree, a child development
93.15 associate credential, a diploma in child development from a Minnesota state technical
93.16 college, or a bachelor's or post baccalaureate degree in early childhood education from
93.17 an accredited college or university, or who is accredited by the National Association for
93.18 Family Child Care or the Competency Based Training and Assessment Program. For a
93.19 child care center, accreditation includes accreditation that meets the following criteria:
93.20 the accrediting organization must demonstrate the use of standards that promote the
93.21 physical, social, emotional, and cognitive development of children. The accreditation
93.22 standards shall include, but are not limited to, positive interactions between adults and
93.23 children, age-appropriate learning activities, a system of tracking children's learning,
93.24 use of assessment to meet children's needs, specific qualifications for staff, a learning
93.25 environment that supports developmentally appropriate experiences for children, health
93.26 and safety requirements, and family engagement strategies. ~~The commissioner of human
93.27 services, in conjunction with the commissioners of education and health, will develop an
93.28 application and approval process based on the criteria in this section and any additional
93.29 criteria. The process developed by the commissioner of human services must address
93.30 periodic reassessment of approved accreditations. The commissioner of human services
93.31 must report the criteria developed, the application, approval, and reassessment processes,
93.32 and any additional recommendations by February 15, 2013, to the chairs and ranking
93.33 minority members of the legislative committees having jurisdiction over early childhood
93.34 issues. Based on an application process developed by the commissioner in conjunction
93.35 with the commissioners of education and health, the Department of Human Services must~~

94.1 accept applications from accrediting organizations beginning on July 1, 2013, and on an
94.2 annual basis thereafter. The provider rate differential shall be paid to centers holding an
94.3 accreditation from an approved accrediting organization beginning on a billing cycle to be
94.4 determined by the commissioner, no later than the last Monday in February of a calendar
94.5 year. The commissioner shall annually publish a list of approved accrediting organizations.
94.6 An approved accreditation must be reassessed by the commissioner every two years. If an
94.7 approved accrediting organization is determined to no longer meet the approval criteria, the
94.8 organization and centers being paid the differential under that accreditation must be given
94.9 a 90-day notice by the commissioner and the differential payment must end after a 15-day
94.10 notice to affected families and centers as directed in Minnesota Rules, part 3400.0185,
94.11 subparts 3 and 4. The following accreditations shall be recognized for the provider rate
94.12 differential until an approval process is implemented: the National Association for the
94.13 Education of Young Children, the Council on Accreditation, the National Early Childhood
94.14 Program Accreditation, the National School-Age Care Association, or the National Head
94.15 Start Association Program of Excellence. For Montessori programs, accreditation includes
94.16 the American Montessori Society, Association of Montessori International-USA, or the
94.17 National Center for Montessori Education.

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

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

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

94.26 Sec. 10. Minnesota Statutes 2012, section 119B.13, is amended by adding a subdivision
94.27 to read:

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

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

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

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

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

95.4 Sec. 11. Minnesota Statutes 2012, section 119B.13, subdivision 6, is amended to read:

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

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

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

95.21 (d) A county may refuse to issue a child care authorization to a licensed or legal
95.22 nonlicensed provider, revoke an existing child care authorization to a licensed or legal
95.23 nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or
95.24 refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

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

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

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

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

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

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

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

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

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

96.11 Sec. 12. Minnesota Statutes 2012, section 119B.13, subdivision 7, is amended to read:

96.12 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
96.13 must not be reimbursed for more than ~~ten~~ 25 full-day absent days per child, excluding
96.14 holidays, in a fiscal year, or for more than ten consecutive full-day absent days. Legal
96.15 nonlicensed family child care providers must not be reimbursed for absent days. If a child
96.16 attends for part of the time authorized to be in care in a day, but is absent for part of the
96.17 time authorized to be in care in that same day, the absent time must be reimbursed but
96.18 the time must not count toward the ~~ten~~ absent day days limit. Child care providers must
96.19 only be reimbursed for absent days if the provider has a written policy for child absences
96.20 and charges all other families in care for similar absences.

96.21 (b) Notwithstanding paragraph (a), children with documented medical conditions
96.22 that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive
96.23 full-day absent days limit. Absences due to a documented medical condition of a parent
96.24 or sibling who lives in the same residence as the child receiving child care assistance
96.25 do not count against the absent days limit in a fiscal year. Documentation of medical
96.26 conditions must be on the forms and submitted according to the timelines established by
96.27 the commissioner. A public health nurse or school nurse may verify the illness in lieu of
96.28 a medical practitioner. If a provider sends a child home early due to a medical reason,
96.29 including, but not limited to, fever or contagious illness, the child care center director or
96.30 lead teacher may verify the illness in lieu of a medical practitioner.

96.31 ~~(b)~~ (c) Notwithstanding paragraph (a), children in families may exceed the ~~ten~~ absent
96.32 days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school
96.33 or general equivalency diploma; and (3) is a student in a school district or another similar
96.34 program that provides or arranges for child care, parenting support, social services, career
96.35 and employment supports, and academic support to achieve high school graduation, upon

97.1 request of the program and approval of the county. If a child attends part of an authorized
97.2 day, payment to the provider must be for the full amount of care authorized for that day.

97.3 ~~(e)~~ (d) Child care providers must be reimbursed for up to ten federal or state holidays
97.4 or designated holidays per year when the provider charges all families for these days and the
97.5 holiday or designated holiday falls on a day when the child is authorized to be in attendance.
97.6 Parents may substitute other cultural or religious holidays for the ten recognized state and
97.7 federal holidays. Holidays do not count toward the ~~ten absent day~~ days limit.

97.8 ~~(d)~~ (e) A family or child care provider must not be assessed an overpayment for an
97.9 absent day payment unless (1) there was an error in the amount of care authorized for the
97.10 family, (2) all of the allowed full-day absent payments for the child have been paid, or (3)
97.11 the family or provider did not timely report a change as required under law.

97.12 ~~(e)~~ (f) The provider and family shall receive notification of the number of absent
97.13 days used upon initial provider authorization for a family and ongoing notification of the
97.14 number of absent days used as of the date of the notification.

97.15 (g) For purposes of this subdivision, "absent days limit" means 25 full-day absent
97.16 days per child, excluding holidays, in a fiscal year; and ten consecutive full-day absent days.

97.17 **EFFECTIVE DATE.** This section is effective February 1, 2014.

97.18 Sec. 13. Minnesota Statutes 2012, section 245A.07, subdivision 2a, is amended to read:

97.19 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days
97.20 of receipt of the license holder's timely appeal, the commissioner shall request assignment
97.21 of an administrative law judge. The request must include a proposed date, time, and place
97.22 of a hearing. A hearing must be conducted by an administrative law judge within 30
97.23 calendar days of the request for assignment, unless an extension is requested by either
97.24 party and granted by the administrative law judge for good cause. The commissioner shall
97.25 issue a notice of hearing by certified mail or personal service at least ten working days
97.26 before the hearing. The scope of the hearing shall be limited solely to the issue of whether
97.27 the temporary immediate suspension should remain in effect pending the commissioner's
97.28 final order under section 245A.08, regarding a licensing sanction issued under subdivision
97.29 3 following the immediate suspension. The burden of proof in expedited hearings under
97.30 this subdivision shall be limited to the commissioner's demonstration that reasonable
97.31 cause exists to believe that the license holder's actions or failure to comply with applicable
97.32 law or rule poses, or if the actions of other individuals or conditions in the program
97.33 poses an imminent risk of harm to the health, safety, or rights of persons served by the
97.34 program. "Reasonable cause" means there exist specific articulable facts or circumstances
97.35 which provide the commissioner with a reasonable suspicion that there is an imminent

98.1 risk of harm to the health, safety, or rights of persons served by the program. When the
98.2 commissioner has determined there is reasonable cause to order the temporary immediate
98.3 suspension of a license based on a violation of safe sleep requirements, as defined in
98.4 section 245A.1435, the commissioner is not required to demonstrate that an infant died or
98.5 was injured as a result of the safe sleep violations.

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

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

98.20 Sec. 14. Minnesota Statutes 2012, section 245A.1435, is amended to read:

98.21 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT**
98.22 **DEATH SYNDROME IN LICENSED PROGRAMS.**

98.23 (a) When a license holder is placing an infant to sleep, the license holder must
98.24 place the infant on the infant's back, unless the license holder has documentation from
98.25 the infant's ~~parent~~ physician directing an alternative sleeping position for the infant. The
98.26 ~~parent~~ physician directive must be on a form approved by the commissioner and must
98.27 ~~include a statement that the parent or legal guardian has read the information provided by~~
98.28 ~~the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance~~
98.29 ~~of placing an infant or child on its back to sleep to reduce the risk of SIDS.~~ remain on file
98.30 at the licensed location. An infant who independently rolls onto its stomach after being
98.31 placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant
98.32 is at least six months of age or the license holder has a signed statement from the parent
98.33 indicating that the infant regularly rolls over at home.

98.34 (b) ~~The license holder must place the infant in a crib directly on a firm mattress with~~
98.35 ~~a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be~~

99.1 dislodged by pulling on the corner of the sheet. The license holder must not place pillows,
99.2 quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib
99.3 with the infant. The license holder must place the infant in a crib directly on a firm mattress
99.4 with a fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress,
99.5 and overlaps the underside of the mattress so it cannot be dislodged by pulling on the
99.6 corner of the sheet with reasonable effort. The license holder must not place anything in
99.7 the crib with the infant except for the infant's pacifier, as defined in Code of Federal
99.8 Regulations, title 16, part 1511. The requirements of this section apply to license holders
99.9 serving infants up to and including 12 months younger than one year of age. Licensed
99.10 child care providers must meet the crib requirements under section 245A.146.

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

99.18 (d) Placing a swaddled infant down to sleep in a licensed setting is not recommended
99.19 for an infant of any age and is prohibited for any infant who has begun to roll over
99.20 independently. However, with the written consent of a parent or guardian according to this
99.21 paragraph, a license holder may place the infant who has not yet begun to roll over on its
99.22 own down to sleep in a one-piece sleeper equipped with an attached system that fastens
99.23 securely only across the upper torso, with no constriction of the hips or legs, to create a
99.24 swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter,
99.25 the license holder must obtain informed written consent for the use of swaddling from the
99.26 parent or guardian of the infant on a form provided by the commissioner and prepared in
99.27 partnership with the Minnesota Sudden Infant Death Center.

99.28 Sec. 15. Minnesota Statutes 2012, section 245A.144, is amended to read:

99.29 **245A.144 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
99.30 **DEATH AND SHAKEN BABY SYNDROME ABUSIVE HEAD TRAUMA FOR**
99.31 **CHILD FOSTER CARE PROVIDERS.**

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

100.1 death ~~syndrome~~ and ~~shaken baby syndrome~~ for abusive head trauma from shaking infants
100.2 and young children. This section does not apply to emergency relative placement under
100.3 section 245A.035. The training on reducing the risk of sudden unexpected infant death
100.4 ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma may be provided as:

100.5 (1) orientation training to child foster care providers, who care for infants or children
100.6 through five years of age, under Minnesota Rules, part 2960.3070, subpart 1; or

100.7 (2) in-service training to child foster care providers, who care for infants or children
100.8 through five years of age, under Minnesota Rules, part 2960.3070, subpart 2.

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

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

100.20 Sec. 16. Minnesota Statutes 2012, section 245A.1444, is amended to read:

100.21 **245A.1444 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
100.22 **~~DEATH SYNDROME~~ AND ~~SHAKEN-BABY SYNDROME~~ ABUSIVE HEAD**
100.23 **TRAUMA BY OTHER PROGRAMS.**

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

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

101.1 Sec. 17. **[245A.1446] FAMILY CHILD CARE DIAPERING AREA**

101.2 **DISINFECTION.**

101.3 Notwithstanding Minnesota Rules, part 9502.0435, a family child care provider may
101.4 disinfect the diaper changing surface with chlorine bleach in a manner consistent with label
101.5 directions for disinfection or with a surface disinfectant that meets the following criteria:

101.6 (1) the manufacturer's label or instructions state that the product is registered with
101.7 the United States Environmental Protection Agency;

101.8 (2) the manufacturer's label or instructions state that the disinfectant is effective
101.9 against Staphylococcus aureus, Salmonella choleraesuis, and Pseudomonas aeruginosa;

101.10 (3) the manufacturer's label or instructions state that the disinfectant is effective with
101.11 a ten minute or less contact time;

101.12 (4) the disinfectant is clearly labeled by the manufacturer with directions for mixing
101.13 and use;

101.14 (5) the disinfectant is used only in accordance with the manufacturer's directions; and

101.15 (6) the product does not include triclosan or derivatives of triclosan.

101.16 Sec. 18. **[245A.147] FAMILY CHILD CARE INFANT SLEEP SUPERVISION**

101.17 **REQUIREMENTS.**

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

101.21 (b) Upon enrollment of an infant in a family child care program, the license holder is
101.22 encouraged to conduct in-person checks on the sleeping infant every 15 minutes, during
101.23 the first four months of care.

101.24 (c) When an infant has an upper respiratory infection, the license holder is
101.25 encouraged to conduct in-person checks on the sleeping infant every 15 minutes
101.26 throughout the hours of sleep.

101.27 Subd. 2. **Use of audio or visual monitoring devices.** In addition to conducting
101.28 the in-person checks encouraged under subdivision 1, license holders serving infants are
101.29 encouraged to use and maintain an audio or visual monitoring device to monitor each
101.30 sleeping infant in care during all hours of sleep.

101.31 Sec. 19. **[245A.152] CHILD CARE LICENSE HOLDER INSURANCE.**

101.32 (a) A license holder must provide a written notice to all parents or guardians of all
101.33 children to be accepted for care prior to admission stating whether the license holder has

102.1 liability insurance. This notice may be incorporated into and provided on the admission
102.2 form used by the license holder.

102.3 (b) If the license holder has liability insurance:

102.4 (1) the license holder shall inform parents in writing that a current certificate of
102.5 coverage for insurance is available for inspection to all parents or guardians of children
102.6 receiving services and to all parents seeking services from the family child care program;

102.7 (2) the notice must provide the parent or guardian with the date of expiration or
102.8 next renewal of the policy; and

102.9 (3) upon the expiration date of the policy, the license holder must provide a new
102.10 written notice indicating whether the insurance policy has lapsed or whether the license
102.11 holder has renewed the policy.

102.12 If the policy was renewed, the license holder must provide the new expiration date of the
102.13 policy in writing to the parents or guardians.

102.14 (c) If the license holder does not have liability insurance, the license holder must
102.15 provide an annual notice, on a form developed and made available by the commissioner,
102.16 to the parents or guardians of children in care indicating that the license holder does not
102.17 carry liability insurance.

102.18 (d) The license holder must notify all parents and guardians in writing immediately
102.19 of any change in insurance status.

102.20 (e) The license holder must make available upon request the certificate of liability
102.21 insurance to the parents of children in care, to the commissioner, and to county licensing
102.22 agents.

102.23 (f) The license holder must document, with the signature of the parent or guardian,
102.24 that the parent or guardian received the notices required by this section.

102.25 Sec. 20. Minnesota Statutes 2012, section 245A.40, subdivision 5, is amended to read:

102.26 Subd. 5. **Sudden unexpected infant death syndrome and ~~shaken baby syndrome~~**
102.27 **abusive head trauma training.** (a) License holders must document that before staff
102.28 persons and volunteers care for infants, they are instructed on the standards in section
102.29 245A.1435 and receive training on reducing the risk of sudden unexpected infant death
102.30 ~~syndrome~~. In addition, license holders must document that before staff persons care for
102.31 infants or children under school age, they receive training on the risk of ~~shaken baby~~
102.32 ~~syndrome~~ abusive head trauma from shaking infants and young children. The training
102.33 in this subdivision may be provided as orientation training under subdivision 1 and
102.34 in-service training under subdivision 7.

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

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

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

103.20 Sec. 21. Minnesota Statutes 2012, section 245A.50, is amended to read:

103.21 **245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.**

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

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

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

104.1 must be repeated annually. Training curriculum shall be developed or approved by the
104.2 commissioner of human services by January 1, 2014.

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

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

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

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

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

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

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

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

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

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

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

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

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

105.8 **Subd. 5. Sudden unexpected infant death syndrome and shaken baby syndrome**
105.9 **abusive head trauma training.** (a) License holders must document that before staff
105.10 persons, caregivers, and helpers assist in the care of infants, they are instructed on the
105.11 standards in section 245A.1435 and receive training on reducing the risk of sudden
105.12 unexpected infant death syndrome. In addition, license holders must document that before
105.13 staff persons, caregivers, and helpers assist in the care of infants and children under
105.14 school age, they receive training on reducing the risk of ~~shaken baby syndrome~~ abusive
105.15 head trauma from shaking infants and young children. The training in this subdivision
105.16 may be provided as initial training under subdivision 1 or ongoing annual training under
105.17 subdivision 7.

105.18 (b) ~~Sudden unexpected infant death syndrome~~ reduction training required under this
105.19 subdivision must be at least one-half hour in length and must be completed in person
105.20 at least once every ~~five years~~ two years. On the years when the license holder is not
105.21 receiving the in-person training on sudden unexpected infant death reduction, the license
105.22 holder must receive sudden unexpected infant death reduction training through a video
105.23 of no more than one hour in length developed or approved by the commissioner. At a
105.24 minimum, the training must address the risk factors related to sudden unexpected infant
105.25 death syndrome, means of reducing the risk of sudden unexpected infant death syndrome
105.26 in child care, and license holder communication with parents regarding reducing the risk
105.27 of sudden unexpected infant death syndrome.

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

105.35 (d) Training for family and group family child care providers must be developed
105.36 by the commissioner in conjunction with the Minnesota Sudden Infant Death Center

106.1 and approved by the county licensing agency by the Minnesota Center for Professional
106.2 Development.

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

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

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

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

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

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

106.30 (c) Child care providers that only transport school-age children as defined in section
106.31 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
106.32 subdivision 1, paragraph (e), are exempt from this subdivision.

106.33 Subd. 7. **Training requirements for family and group family child care.** For
106.34 purposes of family and group family child care, the license holder and each primary
106.35 caregiver must complete ~~eight~~ 16 hours of ongoing training each year. For purposes
106.36 of this subdivision, a primary caregiver is an adult caregiver who provides services in

107.1 the licensed setting for more than 30 days in any 12-month period. Repeat of topical
107.2 training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training
107.3 requirement. Additional ongoing training subjects to meet the annual 16-hour training
107.4 requirement must be selected from the following areas:

107.5 (1) "child growth and development training" ~~has the meaning given in~~ under
107.6 subdivision 2, paragraph (a);

107.7 (2) "learning environment and curriculum" ~~includes,~~ including training in
107.8 establishing an environment and providing activities that provide learning experiences to
107.9 meet each child's needs, capabilities, and interests;

107.10 (3) "assessment and planning for individual needs" ~~includes,~~ including training in
107.11 observing and assessing what children know and can do in order to provide curriculum
107.12 and instruction that addresses their developmental and learning needs, including children
107.13 with special needs and bilingual children or children for whom English is not their
107.14 primary language;

107.15 (4) "interactions with children" ~~includes,~~ including training in establishing
107.16 supportive relationships with children, guiding them as individuals and as part of a group;

107.17 (5) "families and communities" ~~includes,~~ including training in working
107.18 collaboratively with families and agencies or organizations to meet children's needs and to
107.19 encourage the community's involvement;

107.20 (6) "health, safety, and nutrition" ~~includes,~~ including training in establishing and
107.21 maintaining an environment that ensures children's health, safety, and nourishment,
107.22 including child abuse, maltreatment, prevention, and reporting; home and fire safety; child
107.23 injury prevention; communicable disease prevention and control; first aid; and CPR; ~~and~~

107.24 (7) "program planning and evaluation" ~~includes,~~ including training in establishing,
107.25 implementing, evaluating, and enhancing program operations; and

107.26 (8) behavior guidance, including training in the understanding of the functions of
107.27 child behavior and strategies for managing behavior.

107.28 Subd. 8. **Other required training requirements.** (a) The training required of
107.29 family and group family child care providers and staff must include training in the cultural
107.30 dynamics of early childhood development and child care. The cultural dynamics and
107.31 disabilities training and skills development of child care providers must be designed to
107.32 achieve outcomes for providers of child care that include, but are not limited to:

107.33 (1) an understanding and support of the importance of culture and differences in
107.34 ability in children's identity development;

107.35 (2) understanding the importance of awareness of cultural differences and
107.36 similarities in working with children and their families;

108.1 (3) understanding and support of the needs of families and children with differences
108.2 in ability;

108.3 (4) developing skills to help children develop unbiased attitudes about cultural
108.4 differences and differences in ability;

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

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

108.7 The commissioner shall approve the curriculum for cultural dynamics and disability
108.8 training.

108.9 (b) The provider must meet the training requirement in section 245A.14, subdivision
108.10 11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child
108.11 care or group family child care home to use the swimming pool located at the home.

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

108.21 Subd. 10. **Approved training.** County licensing staff must accept training approved
108.22 by the Minnesota Center for Professional Development, including:

108.23 (1) face-to-face or classroom training;

108.24 (2) online training; and

108.25 (3) relationship-based professional development, such as mentoring, coaching,
108.26 and consulting.

108.27 Subd. 11. **Provider training.** New and increased training requirements under this
108.28 section must not be imposed on providers until the commissioner establishes statewide
108.29 accessibility to the required provider training.

108.30 Sec. 22. Minnesota Statutes 2012, section 252.27, subdivision 2a, is amended to read:

108.31 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
108.32 child, including a child determined eligible for medical assistance without consideration of
108.33 parental income, must contribute to the cost of services used by making monthly payments
108.34 on a sliding scale based on income, unless the child is married or has been married, parental
108.35 rights have been terminated, or the child's adoption is subsidized according to section

109.1 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial
109.2 or full payment for medical services provided for diagnostic, therapeutic, curing, treating,
109.3 mitigating, rehabilitation, maintenance, and personal care services as defined in United
109.4 States Code, title 26, section 213, needed by the child with a chronic illness or disability.

109.5 (b) For households with adjusted gross income equal to or greater than ~~100~~ 275
109.6 percent of federal poverty guidelines, the parental contribution shall be computed by
109.7 applying the following schedule of rates to the adjusted gross income of the natural or
109.8 adoptive parents:

109.9 ~~(1) if the adjusted gross income is equal to or greater than 100 percent of federal~~
109.10 ~~poverty guidelines and less than 175 percent of federal poverty guidelines, the parental~~
109.11 ~~contribution is \$4 per month;~~

109.12 ~~(2)~~ (1) if the adjusted gross income is equal to or greater than ~~175~~ 275 percent
109.13 of federal poverty guidelines and less than or equal to 545 percent of federal poverty
109.14 guidelines, the parental contribution shall be determined using a sliding fee scale
109.15 established by the commissioner of human services which begins at ~~one~~ 2.76 percent of
109.16 adjusted gross income at ~~175~~ 275 percent of federal poverty guidelines and increases to
109.17 7.5 percent of adjusted gross income for those with adjusted gross income up to 545
109.18 percent of federal poverty guidelines;

109.19 ~~(3)~~ (2) if the adjusted gross income is greater than 545 percent of federal poverty
109.20 guidelines and less than 675 percent of federal poverty guidelines, the parental
109.21 contribution shall be 7.5 percent of adjusted gross income;

109.22 ~~(4)~~ (3) if the adjusted gross income is equal to or greater than 675 percent of federal
109.23 poverty guidelines and less than 975 percent of federal poverty guidelines, the parental
109.24 contribution shall be determined using a sliding fee scale established by the commissioner
109.25 of human services which begins at 7.5 percent of adjusted gross income at 675 percent of
109.26 federal poverty guidelines and increases to ten percent of adjusted gross income for those
109.27 with adjusted gross income up to 975 percent of federal poverty guidelines; and

109.28 ~~(5)~~ (4) if the adjusted gross income is equal to or greater than 975 percent of federal
109.29 poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.

109.30 If the child lives with the parent, the annual adjusted gross income is reduced by
109.31 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
109.32 specified in section 256B.35, the parent is responsible for the personal needs allowance
109.33 specified under that section in addition to the parental contribution determined under this
109.34 section. The parental contribution is reduced by any amount required to be paid directly to
109.35 the child pursuant to a court order, but only if actually paid.

110.1 (c) The household size to be used in determining the amount of contribution under
110.2 paragraph (b) includes natural and adoptive parents and their dependents, including the
110.3 child receiving services. Adjustments in the contribution amount due to annual changes
110.4 in the federal poverty guidelines shall be implemented on the first day of July following
110.5 publication of the changes.

110.6 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
110.7 natural or adoptive parents determined according to the previous year's federal tax form,
110.8 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
110.9 have been used to purchase a home shall not be counted as income.

110.10 (e) The contribution shall be explained in writing to the parents at the time eligibility
110.11 for services is being determined. The contribution shall be made on a monthly basis
110.12 effective with the first month in which the child receives services. Annually upon
110.13 redetermination or at termination of eligibility, if the contribution exceeded the cost of
110.14 services provided, the local agency or the state shall reimburse that excess amount to
110.15 the parents, either by direct reimbursement if the parent is no longer required to pay a
110.16 contribution, or by a reduction in or waiver of parental fees until the excess amount is
110.17 exhausted. All reimbursements must include a notice that the amount reimbursed may be
110.18 taxable income if the parent paid for the parent's fees through an employer's health care
110.19 flexible spending account under the Internal Revenue Code, section 125, and that the
110.20 parent is responsible for paying the taxes owed on the amount reimbursed.

110.21 (f) The monthly contribution amount must be reviewed at least every 12 months;
110.22 when there is a change in household size; and when there is a loss of or gain in income
110.23 from one month to another in excess of ten percent. The local agency shall mail a written
110.24 notice 30 days in advance of the effective date of a change in the contribution amount.
110.25 A decrease in the contribution amount is effective in the month that the parent verifies a
110.26 reduction in income or change in household size.

110.27 (g) Parents of a minor child who do not live with each other shall each pay the
110.28 contribution required under paragraph (a). An amount equal to the annual court-ordered
110.29 child support payment actually paid on behalf of the child receiving services shall be
110.30 deducted from the adjusted gross income of the parent making the payment prior to
110.31 calculating the parental contribution under paragraph (b).

110.32 (h) The contribution under paragraph (b) shall be increased by an additional five
110.33 percent if the local agency determines that insurance coverage is available but not
110.34 obtained for the child. For purposes of this section, "available" means the insurance is a
110.35 benefit of employment for a family member at an annual cost of no more than five percent
110.36 of the family's annual income. For purposes of this section, "insurance" means health

111.1 and accident insurance coverage, enrollment in a nonprofit health service plan, health
111.2 maintenance organization, self-insured plan, or preferred provider organization.

111.3 Parents who have more than one child receiving services shall not be required
111.4 to pay more than the amount for the child with the highest expenditures. There shall
111.5 be no resource contribution from the parents. The parent shall not be required to pay
111.6 a contribution in excess of the cost of the services provided to the child, not counting
111.7 payments made to school districts for education-related services. Notice of an increase in
111.8 fee payment must be given at least 30 days before the increased fee is due.

111.9 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if,
111.10 in the 12 months prior to July 1:

111.11 (1) the parent applied for insurance for the child;

111.12 (2) the insurer denied insurance;

111.13 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
111.14 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
111.15 commerce, or litigated the complaint or appeal; and

111.16 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

111.17 For purposes of this section, "insurance" has the meaning given in paragraph (h).

111.18 A parent who has requested a reduction in the contribution amount under this
111.19 paragraph shall submit proof in the form and manner prescribed by the commissioner or
111.20 county agency, including, but not limited to, the insurer's denial of insurance, the written
111.21 letter or complaint of the parents, court documents, and the written response of the insurer
111.22 approving insurance. The determinations of the commissioner or county agency under this
111.23 paragraph are not rules subject to chapter 14.

111.24 ~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30,~~
111.25 ~~2015, the parental contribution shall be computed by applying the following contribution~~
111.26 ~~schedule to the adjusted gross income of the natural or adoptive parents:~~

111.27 ~~(1) if the adjusted gross income is equal to or greater than 100 percent of federal~~
111.28 ~~poverty guidelines and less than 175 percent of federal poverty guidelines, the parental~~
111.29 ~~contribution is \$4 per month;~~

111.30 ~~(2) if the adjusted gross income is equal to or greater than 175 percent of federal~~
111.31 ~~poverty guidelines and less than or equal to 525 percent of federal poverty guidelines,~~
111.32 ~~the parental contribution shall be determined using a sliding fee scale established by the~~
111.33 ~~commissioner of human services which begins at one percent of adjusted gross income~~
111.34 ~~at 175 percent of federal poverty guidelines and increases to eight percent of adjusted~~
111.35 ~~gross income for those with adjusted gross income up to 525 percent of federal poverty~~
111.36 ~~guidelines;~~

112.1 ~~(3) if the adjusted gross income is greater than 525 percent of federal poverty~~
112.2 ~~guidelines and less than 675 percent of federal poverty guidelines, the parental~~
112.3 ~~contribution shall be 9.5 percent of adjusted gross income;~~

112.4 ~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal~~
112.5 ~~poverty guidelines and less than 900 percent of federal poverty guidelines, the parental~~
112.6 ~~contribution shall be determined using a sliding fee scale established by the commissioner~~
112.7 ~~of human services which begins at 9.5 percent of adjusted gross income at 675 percent of~~
112.8 ~~federal poverty guidelines and increases to 12 percent of adjusted gross income for those~~
112.9 ~~with adjusted gross income up to 900 percent of federal poverty guidelines; and~~

112.10 ~~(5) if the adjusted gross income is equal to or greater than 900 percent of federal~~
112.11 ~~poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross~~
112.12 ~~income. If the child lives with the parent, the annual adjusted gross income is reduced by~~
112.13 ~~\$2,400 prior to calculating the parental contribution. If the child resides in an institution~~
112.14 ~~specified in section 256B.35, the parent is responsible for the personal needs allowance~~
112.15 ~~specified under that section in addition to the parental contribution determined under this~~
112.16 ~~section. The parental contribution is reduced by any amount required to be paid directly to~~
112.17 ~~the child pursuant to a court order, but only if actually paid.~~

112.18 **EFFECTIVE DATE.** Paragraph (b) is effective January 1, 2014. Paragraph (j)
112.19 is effective July 1, 2013.

112.20 Sec. 23. Minnesota Statutes 2012, section 256.98, subdivision 8, is amended to read:

112.21 Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of
112.22 wrongfully obtaining assistance by a federal or state court or by an administrative hearing
112.23 determination, or waiver thereof, through a disqualification consent agreement, or as part
112.24 of any approved diversion plan under section 401.065, or any court-ordered stay which
112.25 carries with it any probationary or other conditions, in the Minnesota family investment
112.26 program and any affiliated program to include the diversionary work program and the
112.27 work participation cash benefit program, the food stamp or food support program, the
112.28 general assistance program, the group residential housing program, or the Minnesota
112.29 supplemental aid program shall be disqualified from that program. In addition, any person
112.30 disqualified from the Minnesota family investment program shall also be disqualified from
112.31 the food stamp or food support program. The needs of that individual shall not be taken
112.32 into consideration in determining the grant level for that assistance unit:

- 112.33 (1) for one year after the first offense;
- 112.34 (2) for two years after the second offense; and
- 112.35 (3) permanently after the third or subsequent offense.

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

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

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

113.35 (d) Any person found to be guilty of wrongfully obtaining general assistance
113.36 medical care, MinnesotaCare for adults without children, and upon federal approval, all

114.1 categories of medical assistance and remaining categories of MinnesotaCare, except
114.2 for children through age 18, by a federal or state court or by an administrative hearing
114.3 determination, or waiver thereof, through a disqualification consent agreement, or as part
114.4 of any approved diversion plan under section 401.065, or any court-ordered stay which
114.5 carries with it any probationary or other conditions, is disqualified from that program. The
114.6 period of disqualification is one year after the first offense, two years after the second
114.7 offense, and permanently after the third or subsequent offense. The period of program
114.8 disqualification shall begin on the date stipulated on the advance notice of disqualification
114.9 without possibility of postponement for administrative stay or administrative hearing
114.10 and shall continue through completion unless and until the findings upon which the
114.11 sanctions were imposed are reversed by a court of competent jurisdiction. The period for
114.12 which sanctions are imposed is not subject to review. The sanctions provided under this
114.13 subdivision are in addition to, and not in substitution for, any other sanctions that may be
114.14 provided for by law for the offense involved.

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

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

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

114.23 **EFFECTIVE DATE.** This section is effective October 1, 2014, or upon approval
114.24 from the United States Department of Agriculture, whichever is later.

114.25 Sec. 25. Minnesota Statutes 2012, section 256J.21, subdivision 2, is amended to read:

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

114.28 (1) payments for basic care, difficulty of care, and clothing allowances received for
114.29 providing family foster care to children or adults under Minnesota Rules, parts 9555.5050
114.30 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used
114.31 for care and maintenance of a third-party beneficiary who is not a household member;

114.32 (2) reimbursements for employment training received through the Workforce
114.33 Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

115.1 (3) reimbursement for out-of-pocket expenses incurred while performing volunteer
115.2 services, jury duty, employment, or informal carpooling arrangements directly related to
115.3 employment;

115.4 (4) all educational assistance, except the county agency must count graduate student
115.5 teaching assistantships, fellowships, and other similar paid work as earned income and,
115.6 after allowing deductions for any unmet and necessary educational expenses, shall
115.7 count scholarships or grants awarded to graduate students that do not require teaching
115.8 or research as unearned income;

115.9 (5) loans, regardless of purpose, from public or private lending institutions,
115.10 governmental lending institutions, or governmental agencies;

115.11 (6) loans from private individuals, regardless of purpose, provided an applicant or
115.12 participant documents that the lender expects repayment;

115.13 (7)(i) state income tax refunds; and

115.14 (ii) federal income tax refunds;

115.15 (8)(i) federal earned income credits;

115.16 (ii) Minnesota working family credits;

115.17 (iii) state homeowners and renters credits under chapter 290A; and

115.18 (iv) federal or state tax rebates;

115.19 (9) funds received for reimbursement, replacement, or rebate of personal or real
115.20 property when these payments are made by public agencies, awarded by a court, solicited
115.21 through public appeal, or made as a grant by a federal agency, state or local government,
115.22 or disaster assistance organizations, subsequent to a presidential declaration of disaster;

115.23 (10) the portion of an insurance settlement that is used to pay medical, funeral, and
115.24 burial expenses, or to repair or replace insured property;

115.25 (11) reimbursements for medical expenses that cannot be paid by medical assistance;

115.26 (12) payments by a vocational rehabilitation program administered by the state
115.27 under chapter 268A, except those payments that are for current living expenses;

115.28 (13) in-kind income, including any payments directly made by a third party to a
115.29 provider of goods and services;

115.30 (14) assistance payments to correct underpayments, but only for the month in which
115.31 the payment is received;

115.32 (15) payments for short-term emergency needs under section 256J.626, subdivision 2;

115.33 (16) funeral and cemetery payments as provided by section 256.935;

115.34 (17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in
115.35 a calendar month;

116.1 (18) any form of energy assistance payment made through Public Law 97-35,
116.2 Low-Income Home Energy Assistance Act of 1981, payments made directly to energy
116.3 providers by other public and private agencies, and any form of credit or rebate payment
116.4 issued by energy providers;

116.5 (19) Supplemental Security Income (SSI), including retroactive SSI payments and
116.6 other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;

116.7 (20) Minnesota supplemental aid, including retroactive payments;

116.8 (21) proceeds from the sale of real or personal property;

116.9 (22) state adoption assistance payments under section 259.67, and up to an equal
116.10 amount of county adoption assistance payments;

116.11 (23) state-funded family subsidy program payments made under section 252.32 to
116.12 help families care for children with developmental disabilities, consumer support grant
116.13 funds under section 256.476, and resources and services for a disabled household member
116.14 under one of the home and community-based waiver services programs under chapter 256B;

116.15 (24) interest payments and dividends from property that is not excluded from and
116.16 that does not exceed the asset limit;

116.17 (25) rent rebates;

116.18 (26) income earned by a minor caregiver, minor child through age 6, or a minor
116.19 child who is at least a half-time student in an approved elementary or secondary education
116.20 program;

116.21 (27) income earned by a caregiver under age 20 who is at least a half-time student in
116.22 an approved elementary or secondary education program;

116.23 (28) MFIP child care payments under section 119B.05;

116.24 (29) all other payments made through MFIP to support a caregiver's pursuit of
116.25 greater economic stability;

116.26 (30) income a participant receives related to shared living expenses;

116.27 (31) reverse mortgages;

116.28 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title
116.29 42, chapter 13A, sections 1771 to 1790;

116.30 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
116.31 United States Code, title 42, chapter 13A, section 1786;

116.32 (34) benefits from the National School Lunch Act, United States Code, title 42,
116.33 chapter 13, sections 1751 to 1769e;

116.34 (35) relocation assistance for displaced persons under the Uniform Relocation
116.35 Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title

117.1 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States
117.2 Code, title 12, chapter 13, sections 1701 to 1750jj;

117.3 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter
117.4 12, part 2, sections 2271 to 2322;

117.5 (37) war reparations payments to Japanese Americans and Aleuts under United
117.6 States Code, title 50, sections 1989 to 1989d;

117.7 (38) payments to veterans or their dependents as a result of legal settlements
117.8 regarding Agent Orange or other chemical exposure under Public Law 101-239, section
117.9 10405, paragraph (a)(2)(E);

117.10 (39) income that is otherwise specifically excluded from MFIP consideration in
117.11 federal law, state law, or federal regulation;

117.12 (40) security and utility deposit refunds;

117.13 (41) American Indian tribal land settlements excluded under Public Laws 98-123,
117.14 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech
117.15 Lake, and Mille Lacs reservations and payments to members of the White Earth Band,
117.16 under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

117.17 (42) all income of the minor parent's parents and stepparents when determining the
117.18 grant for the minor parent in households that include a minor parent living with parents or
117.19 stepparents on MFIP with other children;

117.20 (43) income of the minor parent's parents and stepparents equal to 200 percent of the
117.21 federal poverty guideline for a family size not including the minor parent and the minor
117.22 parent's child in households that include a minor parent living with parents or stepparents
117.23 not on MFIP when determining the grant for the minor parent. The remainder of income is
117.24 deemed as specified in section 256J.37, subdivision 1b;

117.25 (44) payments made to children eligible for relative custody assistance under section
117.26 257.85;

117.27 (45) vendor payments for goods and services made on behalf of a client unless the
117.28 client has the option of receiving the payment in cash;

117.29 (46) the principal portion of a contract for deed payment; ~~and~~

117.30 (47) cash payments to individuals enrolled for full-time service as a volunteer under
117.31 AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps
117.32 National, and AmeriCorps NCCC; and

117.33 (48) housing assistance grants under section 256J.35, paragraph (a).

117.34 Sec. 26. Minnesota Statutes 2012, section 256J.21, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

118.28 **EFFECTIVE DATE.** This section is effective October 1, 2014, or upon approval
118.29 from the United States Department of Agriculture, whichever is later.

118.30 Sec. 27. Minnesota Statutes 2012, section 256J.24, subdivision 5, is amended to read:

118.31 Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based
118.32 on the number of persons in the assistance unit eligible for both food and cash assistance
118.33 ~~unless the restrictions in subdivision 6 on the birth of a child apply.~~ The amount of the
118.34 transitional standard is published annually by the Department of Human Services.

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

119.2 Sec. 28. Minnesota Statutes 2012, section 256J.24, subdivision 7, is amended to read:

119.3 Subd. 7. **Family wage level.** The family wage level is 110 percent of the transitional
119.4 standard under subdivision 5 or 6, ~~when applicable, and is the standard used when there is~~
119.5 ~~earned income in the assistance unit. As specified in section 256J.21.~~ If there is earned
119.6 income in the assistance unit, earned income is subtracted from the family wage level to
119.7 determine the amount of the assistance payment, as specified in section 256J.21. The
119.8 assistance payment may not exceed the transitional standard under subdivision 5 or 6,
119.9 or the shared household standard under subdivision 9, whichever is applicable, for the
119.10 assistance unit.

119.11 **EFFECTIVE DATE.** This section is effective October 1, 2014, or upon approval
119.12 from the United States Department of Agriculture, whichever is later.

119.13 Sec. 29. Minnesota Statutes 2012, section 256J.35, is amended to read:

119.14 **256J.35 AMOUNT OF ASSISTANCE PAYMENT.**

119.15 Except as provided in paragraphs (a) to (c), the amount of an assistance payment is
119.16 equal to the difference between the MFIP standard of need or the Minnesota family wage
119.17 level in section 256J.24 and countable income.

119.18 (a) Beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing
119.19 assistance grant of \$110 per month, unless:

119.20 (1) the housing assistance unit is currently receiving public and assisted rental
119.21 subsidies provided through the Department of Housing and Urban Development (HUD)
119.22 and is subject to section 256J.37, subdivision 3a; or

119.23 (2) the assistance unit is a child-only case under section 256J.88.

119.24 ~~(a)~~ (b) When MFIP eligibility exists for the month of application, the amount of
119.25 the assistance payment for the month of application must be prorated from the date of
119.26 application or the date all other eligibility factors are met for that applicant, whichever is
119.27 later. This provision applies when an applicant loses at least one day of MFIP eligibility.

119.28 ~~(b)~~ (c) MFIP overpayments to an assistance unit must be recouped according to
119.29 section 256J.38, subdivision 4.

119.30 ~~(e)~~ (d) An initial assistance payment must not be made to an applicant who is not
119.31 eligible on the date payment is made.

119.32 Sec. 30. Minnesota Statutes 2012, section 256J.621, is amended to read:

120.1 **256J.621 WORK PARTICIPATION CASH BENEFITS.**

120.2 Subdivision 1. Program characteristics. (a) Effective October 1, 2009, upon
120.3 exiting the diversionary work program (DWP) or upon terminating the Minnesota family
120.4 investment program with earnings, a participant who is employed may be eligible for work
120.5 participation cash benefits of \$25 per month to assist in meeting the family's basic needs
120.6 as the participant continues to move toward self-sufficiency.

120.7 (b) To be eligible for work participation cash benefits, the participant shall not
120.8 receive MFIP or diversionary work program assistance during the month and the
120.9 participant or participants must meet the following work requirements:

120.10 (1) if the participant is a single caregiver and has a child under six years of age, the
120.11 participant must be employed at least 87 hours per month;

120.12 (2) if the participant is a single caregiver and does not have a child under six years of
120.13 age, the participant must be employed at least 130 hours per month; or

120.14 (3) if the household is a two-parent family, at least one of the parents must be
120.15 employed 130 hours per month.

120.16 Whenever a participant exits the diversionary work program or is terminated from
120.17 MFIP and meets the other criteria in this section, work participation cash benefits are
120.18 available for up to 24 consecutive months.

120.19 (c) Expenditures on the program are maintenance of effort state funds under
120.20 a separate state program for participants under paragraph (b), clauses (1) and (2).
120.21 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort
120.22 funds. Months in which a participant receives work participation cash benefits under this
120.23 section do not count toward the participant's MFIP 60-month time limit.

120.24 Subd. 2. Program suspension. (a) Effective December 1, 2014, the work
120.25 participation cash benefits program shall be suspended.

120.26 (b) The commissioner of human services may reinstate the work participation cash
120.27 benefits program if the United States Department of Human Services determines that the
120.28 state of Minnesota did not meet the federal TANF work participation rate and sends a
120.29 notice of penalty to reduce Minnesota's federal TANF block grant authorized under title I
120.30 of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation
120.31 Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005.

120.32 (c) The commissioner shall notify the chairs and ranking minority members of the
120.33 legislative committees with jurisdiction over human services policy and finance of the
120.34 potential penalty and the commissioner's plans to reinstate the work participation cash
120.35 benefit program within 30 days of the date the commissioner receives notification that
120.36 the state failed to meet the federal work participation rate.

121.1 Sec. 31. Minnesota Statutes 2012, section 256J.626, subdivision 7, is amended to read:

121.2 Subd. 7. **Performance base funds.** (a) ~~For the purpose of this section, the following~~
121.3 ~~terms have the meanings given:~~

121.4 (1) ~~"Caseload Reduction Credit" (CRC) means the measure of how much Minnesota~~
121.5 ~~TANF and separate state program caseload has fallen relative to federal fiscal year 2005~~
121.6 ~~based on caseload data from October 1 to September 30:~~

121.7 (2) ~~"TANF participation rate target" means a 50 percent participation rate reduced by~~
121.8 ~~the CRC for the previous year:~~

121.9 (b) ~~(a)~~ For calendar year ~~2010~~ 2016 and yearly thereafter, each county and tribe will
121.10 must be allocated ~~95~~ 100 percent of their initial calendar year allocation. Allocations for
121.11 counties and tribes will ~~will~~ must be allocated ~~additional funds~~ adjusted based on performance
121.12 as follows:

121.13 (1) ~~a county or tribe that achieves the TANF participation rate target or a five~~
121.14 ~~percentage point improvement over the previous year's TANF participation rate under~~
121.15 ~~section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for~~
121.16 ~~the most recent year for which the measurements are available, will receive an additional~~
121.17 ~~allocation equal to 2.5 percent of its initial allocation;~~

121.18 (2) (1) a county or tribe that performs ~~within or~~ above its range of expected
121.19 performance on the annualized three-year self-support index under section 256J.751,
121.20 subdivision 2, clause (6), will must receive an additional allocation equal to 2.5 percent of
121.21 its initial allocation; and

121.22 (3) ~~a county or tribe that does not achieve the TANF participation rate target or~~
121.23 ~~a five percentage point improvement over the previous year's TANF participation rate~~
121.24 ~~under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive~~
121.25 ~~months for the most recent year for which the measurements are available, will not~~
121.26 ~~receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear~~
121.27 ~~improvement plan with the commissioner; or~~

121.28 (4) (2) a county or tribe that does not perform ~~within or above~~ performs below its
121.29 range of expected performance on the annualized three-year self-support index under
121.30 section 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal~~
121.31 ~~to 2.5 percent of its initial allocation until after negotiating~~ for two consecutive years must
121.32 negotiate a multiyear improvement plan with the commissioner. If no improvement is
121.33 shown by the end of the multiyear plan, the county's or tribe's allocation must be decreased
121.34 by 2.5 percent. The decrease must remain in effect until the county or tribe performs
121.35 within or above its range of expected performance.

122.1 (e) ~~(b)~~ For calendar year ~~2009~~ 2016 and yearly thereafter, performance-based funds
122.2 for a federally approved tribal TANF program in which the state and tribe have in place a
122.3 contract under section 256.01, addressing consolidated funding, ~~will~~ must be allocated
122.4 as follows:

122.5 ~~(1) a tribe that achieves the participation rate approved in its federal TANF plan~~
122.6 ~~using the average of 12 consecutive months for the most recent year for which the~~
122.7 ~~measurements are available, will receive an additional allocation equal to 2.5 percent of~~
122.8 ~~its initial allocation; and~~

122.9 ~~(2)~~ (1) a tribe that performs ~~within or~~ above its range of expected performance on the
122.10 annualized three-year self-support index under section 256J.751, subdivision 2, clause (6),
122.11 ~~will~~ must receive an additional allocation equal to 2.5 percent of its initial allocation; or

122.12 ~~(3) a tribe that does not achieve the participation rate approved in its federal TANF~~
122.13 ~~plan using the average of 12 consecutive months for the most recent year for which the~~
122.14 ~~measurements are available, will not receive an additional allocation equal to 2.5 percent~~
122.15 ~~of its initial allocation until after negotiating a multiyear improvement plan with the~~
122.16 ~~commissioner; or~~

122.17 ~~(4)~~ (2) a tribe that ~~does not perform within or above~~ performs below its range of
122.18 expected performance on the annualized three-year self-support index under section
122.19 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal to~~
122.20 ~~2.5 percent until after negotiating~~ for two consecutive years must negotiate a multiyear
122.21 improvement plan with the commissioner. If no improvement is shown by the end of the
122.22 multiyear plan, the tribe's allocation must be decreased by 2.5 percent. The decrease must
122.23 remain in effect until the tribe performs within or above its range of expected performance.

122.24 ~~(d)~~ (c) Funds remaining unallocated after the performance-based allocations
122.25 in paragraph ~~(b)~~ (a) are available to the commissioner for innovation projects under
122.26 subdivision 5.

122.27 ~~(f)~~ (d) If available funds are insufficient to meet county and tribal allocations under
122.28 ~~paragraph~~ paragraphs (a) and (b), the commissioner ~~may make available for allocation~~
122.29 ~~funds that are unobligated and available from the innovation projects through the end of~~
122.30 ~~the current biennium~~ shall proportionally prorate funds to counties and tribes that qualify
122.31 for a bonus under paragraphs (a), clause (1), and (b), clause (2).

122.32 ~~(2) If after the application of clause (1) funds remain insufficient to meet county and~~
122.33 ~~tribal allocations under paragraph (b), the commissioner must proportionally reduce the~~
122.34 ~~allocation of each county and tribe with respect to their maximum allocation available~~
122.35 ~~under paragraph (b).~~

123.1 Sec. 32. **[256J.78] TANF DEMONSTRATION PROJECTS OR WAIVER FROM**
123.2 **FEDERAL RULES AND REGULATIONS.**

123.3 Subdivision 1. **Duties of the commissioner.** The commissioner of human services
123.4 may pursue TANF demonstration projects or waivers of TANF requirements from the
123.5 United States Department of Health and Human Services as needed to allow the state to
123.6 build a more results-oriented Minnesota Family Investment Program to better meet the
123.7 needs of Minnesota families.

123.8 Subd. 2. **Purpose.** The purpose of the TANF demonstration projects or waivers is to:

123.9 (1) replace the federal TANF process measure and its complex administrative
123.10 requirements with state-developed outcomes measures that track adult employment and
123.11 exits from MFIP cash assistance;

123.12 (2) simplify programmatic and administrative requirements; and

123.13 (3) make other policy or programmatic changes that improve the performance of the
123.14 program and the outcomes for participants.

123.15 Subd. 3. **Report to legislature.** The commissioner shall report to the members of
123.16 the legislative committees having jurisdiction over human services issues by March 1,
123.17 2014, regarding the progress of this waiver or demonstration project.

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

123.19 Sec. 33. Minnesota Statutes 2012, section 256K.45, is amended to read:

123.20 **256K.45 RUNAWAY AND HOMELESS YOUTH ACT.**

123.21 Subdivision 1. **Grant program established.** The commissioner of human services
123.22 shall establish a Homeless Youth Act fund and award grants to providers who are
123.23 committed to serving homeless youth and youth at risk of homelessness, to provide
123.24 street and community outreach and drop-in programs, emergency shelter programs,
123.25 and integrated supportive housing and transitional living programs, consistent with the
123.26 program descriptions in this act to reduce the incidence of homelessness among youth.

123.27 ~~Subdivision 1.~~ Subd. 1a. **Definitions.** (a) The definitions in this subdivision apply
123.28 to this section.

123.29 (b) "Commissioner" means the commissioner of human services.

123.30 (c) "Homeless youth" means a person 21 years of age or younger who is
123.31 unaccompanied by a parent or guardian and is without shelter where appropriate care and
123.32 supervision are available, whose parent or legal guardian is unable or unwilling to provide
123.33 shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The
123.34 following are not fixed, regular, or adequate nighttime residences:

124.1 (1) a supervised publicly or privately operated shelter designed to provide temporary
124.2 living accommodations;

124.3 (2) an institution or a publicly or privately operated shelter designed to provide
124.4 temporary living accommodations;

124.5 (3) transitional housing;

124.6 (4) a temporary placement with a peer, friend, or family member that has not offered
124.7 permanent residence, a residential lease, or temporary lodging for more than 30 days; or

124.8 (5) a public or private place not designed for, nor ordinarily used as, a regular
124.9 sleeping accommodation for human beings.

124.10 Homeless youth does not include persons incarcerated or otherwise detained under
124.11 federal or state law.

124.12 (d) "Youth at risk of homelessness" means a person 21 years of age or younger
124.13 whose status or circumstances indicate a significant danger of experiencing homelessness
124.14 in the near future. Status or circumstances that indicate a significant danger may include:
124.15 (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3)
124.16 youth whose parents or primary caregivers are or were previously homeless; (4) youth
124.17 who are exposed to abuse and neglect in their homes; (5) youth who experience conflict
124.18 with parents due to chemical or alcohol dependency, mental health disabilities, or other
124.19 disabilities; and (6) runaways.

124.20 (e) "Runaway" means an unmarried child under the age of 18 years who is absent
124.21 from the home of a parent or guardian or other lawful placement without the consent of
124.22 the parent, guardian, or lawful custodian.

124.23 Subd. 2. **Homeless and runaway youth report.** The commissioner shall ~~develop a~~
124.24 ~~report for homeless youth, youth at risk of homelessness, and runaways. The report shall~~
124.25 ~~include coordination of services as defined under subdivisions 3 to 5~~ prepare a biennial
124.26 report, beginning in February 2015, which provides meaningful information to the
124.27 legislative committees having jurisdiction over the issue of homeless youth, that includes,
124.28 but is not limited to: (1) a list of the areas of the state with the greatest need for services
124.29 and housing for homeless youth, and the level and nature of the needs identified; (2) details
124.30 about grants made; (3) the distribution of funds throughout the state based on population
124.31 need; (4) follow-up information, if available, on the status of homeless youth and whether
124.32 they have stable housing two years after services are provided; and (5) any other outcomes
124.33 for populations served to determine the effectiveness of the programs and use of funding.

124.34 Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in
124.35 centers must provide walk-in access to crisis intervention and ongoing supportive services
124.36 including one-to-one case management services on a self-referral basis. Street and

125.1 community outreach programs must locate, contact, and provide information, referrals,
125.2 and services to homeless youth, youth at risk of homelessness, and runaways. Information,
125.3 referrals, and services provided may include, but are not limited to:

- 125.4 (1) family reunification services;
- 125.5 (2) conflict resolution or mediation counseling;
- 125.6 (3) assistance in obtaining temporary emergency shelter;
- 125.7 (4) assistance in obtaining food, clothing, medical care, or mental health counseling;
- 125.8 (5) counseling regarding violence, ~~prostitution~~ sexual exploitation, substance abuse,
125.9 sexually transmitted diseases, and pregnancy;
- 125.10 (6) referrals to other agencies that provide support services to homeless youth,
125.11 youth at risk of homelessness, and runaways;
- 125.12 (7) assistance with education, employment, and independent living skills;
- 125.13 (8) aftercare services;
- 125.14 (9) specialized services for highly vulnerable runaways and homeless youth,
125.15 including teen parents, emotionally disturbed and mentally ill youth, and sexually
125.16 exploited youth; and
- 125.17 (10) homelessness prevention.

125.18 Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must
125.19 provide homeless youth and runaways with referral and walk-in access to emergency,
125.20 short-term residential care. The program shall provide homeless youth and runaways with
125.21 safe, dignified shelter, including private shower facilities, beds, and at least one meal each
125.22 day; and shall assist a runaway and homeless youth with reunification with the family or
125.23 legal guardian when required or appropriate.

125.24 (b) The services provided at emergency shelters may include, but are not limited to:

- 125.25 (1) family reunification services;
- 125.26 (2) individual, family, and group counseling;
- 125.27 (3) assistance obtaining clothing;
- 125.28 (4) access to medical and dental care and mental health counseling;
- 125.29 (5) education and employment services;
- 125.30 (6) recreational activities;
- 125.31 (7) advocacy and referral services;
- 125.32 (8) independent living skills training;
- 125.33 (9) aftercare and follow-up services;
- 125.34 (10) transportation; and
- 125.35 (11) homelessness prevention.

126.1 Subd. 5. **Supportive housing and transitional living programs.** Transitional
126.2 living programs must help homeless youth and youth at risk of homelessness to find and
126.3 maintain safe, dignified housing. The program may also provide rental assistance and
126.4 related supportive services, or refer youth to other organizations or agencies that provide
126.5 such services. Services provided may include, but are not limited to:

- 126.6 (1) educational assessment and referrals to educational programs;
126.7 (2) career planning, employment, work skill training, and independent living skills
126.8 training;
126.9 (3) job placement;
126.10 (4) budgeting and money management;
126.11 (5) assistance in securing housing appropriate to needs and income;
126.12 (6) counseling regarding violence, ~~prostitution~~ sexual exploitation, substance abuse,
126.13 sexually transmitted diseases, and pregnancy;
126.14 (7) referral for medical services or chemical dependency treatment;
126.15 (8) parenting skills;
126.16 (9) self-sufficiency support services or life skill training;
126.17 (10) aftercare and follow-up services; and
126.18 (11) homelessness prevention.

126.19 Subd. 6. **Funding.** ~~Any Funds appropriated for this section may be expended on~~
126.20 ~~programs described under subdivisions 3 to 5, technical assistance, and capacity building.~~
126.21 ~~Up to four percent of funds appropriated may be used for the purpose of monitoring and~~
126.22 ~~evaluating runaway and homeless youth programs receiving funding under this section.~~
126.23 ~~Funding shall be directed to meet the greatest need, with a significant share of the funding~~
126.24 ~~focused on homeless youth providers in greater Minnesota to meet the greatest need~~
126.25 ~~on a statewide basis.~~

126.26 Sec. 34. Minnesota Statutes 2012, section 256M.40, subdivision 1, is amended to read:

126.27 Subdivision 1. **Formula.** The commissioner shall allocate state funds appropriated
126.28 under this chapter to each county board on a calendar year basis in an amount determined
126.29 according to the formula in paragraphs (a) to (e).

126.30 (a) For calendar years 2011 and 2012, the commissioner shall allocate available
126.31 funds to each county in proportion to that county's share in calendar year 2010.

126.32 (b) For calendar year 2013 and each calendar year thereafter, the commissioner shall
126.33 allocate available funds to each county as follows:

126.34 (1) 75 percent must be distributed on the basis of the county share in calendar year
126.35 2012;

127.1 (2) five percent must be distributed on the basis of the number of persons residing in
127.2 the county as determined by the most recent data of the state demographer;

127.3 (3) ten percent must be distributed on the basis of the number of vulnerable children
127.4 that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, and in
127.5 the county as determined by the most recent data of the commissioner; and

127.6 (4) ten percent must be distributed on the basis of the number of vulnerable adults
127.7 that are subjects of reports under section 626.557 in the county as determined by the most
127.8 recent data of the commissioner.

127.9 (c) For calendar year 2014, the commissioner shall allocate available funds to each
127.10 county as follows:

127.11 (1) 50 percent must be distributed on the basis of the county share in calendar year
127.12 2012;

127.13 (2) Ten percent must be distributed on the basis of the number of persons residing in
127.14 the county as determined by the most recent data of the state demographer;

127.15 (3) 20 percent must be distributed on the basis of the number of vulnerable children
127.16 that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the
127.17 county as determined by the most recent data of the commissioner; and

127.18 (4) 20 percent must be distributed on the basis of the number of vulnerable adults
127.19 that are subjects of reports under section 626.557 in the county as determined by the
127.20 most recent data of the commissioner The commissioner is precluded from changing the
127.21 formula under this subdivision or recommending a change to the legislature without
127.22 public review and input.

127.23 (d) For calendar year 2015, the commissioner shall allocate available funds to each
127.24 county as follows:

127.25 (1) 25 percent must be distributed on the basis of the county share in calendar year
127.26 2012;

127.27 (2) 15 percent must be distributed on the basis of the number of persons residing in
127.28 the county as determined by the most recent data of the state demographer;

127.29 (3) 30 percent must be distributed on the basis of the number of vulnerable children
127.30 that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the
127.31 county as determined by the most recent data of the commissioner; and

127.32 (4) 30 percent must be distributed on the basis of the number of vulnerable adults
127.33 that are subjects of reports under section 626.557 in the county as determined by the most
127.34 recent data of the commissioner.

127.35 (e) For calendar year 2016 and each calendar year thereafter, the commissioner shall
127.36 allocate available funds to each county as follows:

128.1 ~~(1) 20 percent must be distributed on the basis of the number of persons residing in~~
128.2 ~~the county as determined by the most recent data of the state demographer;~~

128.3 ~~(2) 40 percent must be distributed on the basis of the number of vulnerable children~~
128.4 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
128.5 ~~county as determined by the most recent data of the commissioner; and~~

128.6 ~~(3) 40 percent must be distributed on the basis of the number of vulnerable adults~~
128.7 ~~that are subjects of reports under section 626.557 in the county as determined by the most~~
128.8 ~~recent data of the commissioner.~~

128.9 Sec. 35. Minnesota Statutes 2012, section 257.0755, subdivision 1, is amended to read:

128.10 Subdivision 1. **Creation.** ~~One~~ Each ombudsperson shall operate independently from
128.11 but in collaboration with ~~each of the following groups~~ the community-specific board that
128.12 appointed the ombudsperson under section 257.0768: the Indian Affairs Council, the
128.13 Council on Affairs of Chicano/Latino people, the Council on Black Minnesotans, and
128.14 the Council on Asian-Pacific Minnesotans.

128.15 Sec. 36. Minnesota Statutes 2012, section 259A.20, subdivision 4, is amended to read:

128.16 Subd. 4. **Reimbursement for special nonmedical expenses.** (a) Reimbursement
128.17 for special nonmedical expenses is available to children, except those eligible for adoption
128.18 assistance based on being an at-risk child.

128.19 (b) Reimbursements under this paragraph shall be made only after the adoptive
128.20 parent documents that the requested service was denied by the local social service agency,
128.21 community agencies, the local school district, the local public health department, the
128.22 parent's insurance provider, or the child's program. The denial must be for an eligible
128.23 service or qualified item under the program requirements of the applicable agency or
128.24 organization.

128.25 (c) Reimbursements must be previously authorized, adhere to the requirements and
128.26 procedures prescribed by the commissioner, and be limited to:

128.27 (1) child care for a child age 12 and younger, or for a child age 13 or 14 who has a
128.28 documented disability that requires special instruction for and services by the child care
128.29 provider. Child care reimbursements may be made if all available adult caregivers are
128.30 employed, unemployed due to a disability as defined in section 259A.01, subdivision 14,
128.31 or attending educational or vocational training programs. Documentation from a qualified
128.32 expert that is dated within the last 12 months must be provided to verify the disability. If a
128.33 parent is attending an educational or vocational training program, child care reimbursement
128.34 is limited to no more than the time necessary to complete the credit requirements for an

129.1 associate or baccalaureate degree as determined by the educational institution. Child
129.2 care reimbursement is not limited for an adoptive parent completing basic or remedial
129.3 education programs needed to prepare for postsecondary education or employment;
129.4 (2) respite care provided for the relief of the child's parent up to 504 hours of respite
129.5 care annually;
129.6 (3) camping up to 14 days per state fiscal year for a child to attend a special needs
129.7 camp. The camp must be accredited by the American Camp Association as a special needs
129.8 camp in order to be eligible for camp reimbursement;
129.9 (4) postadoption counseling to promote the child's integration into the adoptive
129.10 family that is provided by the placing agency during the first year following the date of the
129.11 adoption decree. Reimbursement is limited to 12 sessions of postadoption counseling;
129.12 (5) family counseling that is required to meet the child's special needs.
129.13 Reimbursement is limited to the prorated portion of the counseling fees allotted to the
129.14 family when the adoptive parent's health insurance or Medicaid pays for the child's
129.15 counseling but does not cover counseling for the rest of the family members;
129.16 (6) home modifications to accommodate the child's special needs upon which
129.17 eligibility for adoption assistance was approved. Reimbursement is limited to once every
129.18 five years per child;
129.19 (7) vehicle modifications to accommodate the child's special needs upon which
129.20 eligibility for adoption assistance was approved. Reimbursement is limited to once every
129.21 five years per family; and
129.22 (8) burial expenses up to \$1,000, if the special needs, upon which eligibility for
129.23 adoption assistance was approved, resulted in the death of the child.
129.24 (d) The adoptive parent shall submit statements for expenses incurred between July
129.25 1 and June 30 of a given fiscal year to the state adoption assistance unit within 60 days
129.26 after the end of the fiscal year in order for reimbursement to occur.

129.27 Sec. 37. Minnesota Statutes 2012, section 260B.007, subdivision 6, is amended to read:

129.28 Subd. 6. **Delinquent child.** (a) Except as otherwise provided in paragraphs (b)
129.29 and (c), "delinquent child" means a child:

129.30 (1) who has violated any state or local law, except as provided in section 260B.225,
129.31 subdivision 1, and except for juvenile offenders as described in subdivisions 16 to 18;

129.32 (2) who has violated a federal law or a law of another state and whose case has been
129.33 referred to the juvenile court if the violation would be an act of delinquency if committed
129.34 in this state or a crime or offense if committed by an adult;

130.1 (3) who has escaped from confinement to a state juvenile correctional facility after
130.2 being committed to the custody of the commissioner of corrections; or

130.3 (4) who has escaped from confinement to a local juvenile correctional facility after
130.4 being committed to the facility by the court.

130.5 (b) The term delinquent child does not include a child alleged to have committed
130.6 murder in the first degree after becoming 16 years of age, but the term delinquent child
130.7 does include a child alleged to have committed attempted murder in the first degree.

130.8 (c) The term delinquent child does not include a child ~~under the age of 16 years~~
130.9 alleged to have engaged in conduct which would, if committed by an adult, violate any
130.10 federal, state, or local law relating to being hired, offering to be hired, or agreeing to be
130.11 hired by another individual to engage in sexual penetration or sexual conduct.

130.12 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
130.13 offenses committed on or after that date.

130.14 Sec. 38. Minnesota Statutes 2012, section 260B.007, subdivision 16, is amended to read:

130.15 Subd. 16. **Juvenile petty offender; juvenile petty offense.** (a) "Juvenile petty
130.16 offense" includes a juvenile alcohol offense, a juvenile controlled substance offense,
130.17 a violation of section 609.685, or a violation of a local ordinance, which by its terms
130.18 prohibits conduct by a child under the age of 18 years which would be lawful conduct if
130.19 committed by an adult.

130.20 (b) Except as otherwise provided in paragraph (c), "juvenile petty offense" also
130.21 includes an offense that would be a misdemeanor if committed by an adult.

130.22 (c) "Juvenile petty offense" does not include any of the following:

130.23 (1) a misdemeanor-level violation of section 518B.01, 588.20, 609.224, 609.2242,
130.24 609.324, subdivision 2 or 3, 609.5632, 609.576, 609.66, 609.746, 609.748, 609.79,
130.25 or 617.23;

130.26 (2) a major traffic offense or an adult court traffic offense, as described in section
130.27 260B.225;

130.28 (3) a misdemeanor-level offense committed by a child whom the juvenile court
130.29 previously has found to have committed a misdemeanor, gross misdemeanor, or felony
130.30 offense; or

130.31 (4) a misdemeanor-level offense committed by a child whom the juvenile court
130.32 has found to have committed a misdemeanor-level juvenile petty offense on two or
130.33 more prior occasions, unless the county attorney designates the child on the petition
130.34 as a juvenile petty offender notwithstanding this prior record. As used in this clause,

131.1 "misdemeanor-level juvenile petty offense" includes a misdemeanor-level offense that
131.2 would have been a juvenile petty offense if it had been committed on or after July 1, 1995.

131.3 (d) A child who commits a juvenile petty offense is a "juvenile petty offender." The
131.4 term juvenile petty offender does not include a child ~~under the age of 16 years~~ alleged
131.5 to have violated any law relating to being hired, offering to be hired, or agreeing to be
131.6 hired by another individual to engage in sexual penetration or sexual conduct which, if
131.7 committed by an adult, would be a misdemeanor.

131.8 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
131.9 offenses committed on or after that date.

131.10 Sec. 39. Minnesota Statutes 2012, section 260C.007, subdivision 6, is amended to read:

131.11 Subd. 6. **Child in need of protection or services.** "Child in need of protection or
131.12 services" means a child who is in need of protection or services because the child:

131.13 (1) is abandoned or without parent, guardian, or custodian;

131.14 (2)(i) has been a victim of physical or sexual abuse as defined in section 626.556,
131.15 subdivision 2, (ii) resides with or has resided with a victim of child abuse as defined in
131.16 subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or
131.17 would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or
131.18 child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment
131.19 as defined in subdivision 15;

131.20 (3) is without necessary food, clothing, shelter, education, or other required care
131.21 for the child's physical or mental health or morals because the child's parent, guardian,
131.22 or custodian is unable or unwilling to provide that care;

131.23 (4) is without the special care made necessary by a physical, mental, or emotional
131.24 condition because the child's parent, guardian, or custodian is unable or unwilling to
131.25 provide that care;

131.26 (5) is medically neglected, which includes, but is not limited to, the withholding of
131.27 medically indicated treatment from a disabled infant with a life-threatening condition. The
131.28 term "withholding of medically indicated treatment" means the failure to respond to the
131.29 infant's life-threatening conditions by providing treatment, including appropriate nutrition,
131.30 hydration, and medication which, in the treating physician's or physicians' reasonable
131.31 medical judgment, will be most likely to be effective in ameliorating or correcting all
131.32 conditions, except that the term does not include the failure to provide treatment other
131.33 than appropriate nutrition, hydration, or medication to an infant when, in the treating
131.34 physician's or physicians' reasonable medical judgment:

131.35 (i) the infant is chronically and irreversibly comatose;

132.1 (ii) the provision of the treatment would merely prolong dying, not be effective in
132.2 ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be
132.3 futile in terms of the survival of the infant; or

132.4 (iii) the provision of the treatment would be virtually futile in terms of the survival
132.5 of the infant and the treatment itself under the circumstances would be inhumane;

132.6 (6) is one whose parent, guardian, or other custodian for good cause desires to be
132.7 relieved of the child's care and custody, including a child who entered foster care under a
132.8 voluntary placement agreement between the parent and the responsible social services
132.9 agency under section 260C.227;

132.10 (7) has been placed for adoption or care in violation of law;

132.11 (8) is without proper parental care because of the emotional, mental, or physical
132.12 disability, or state of immaturity of the child's parent, guardian, or other custodian;

132.13 (9) is one whose behavior, condition, or environment is such as to be injurious or
132.14 dangerous to the child or others. An injurious or dangerous environment may include, but
132.15 is not limited to, the exposure of a child to criminal activity in the child's home;

132.16 (10) is experiencing growth delays, which may be referred to as failure to thrive, that
132.17 have been diagnosed by a physician and are due to parental neglect;

132.18 (11) ~~has engaged in prostitution as defined in section 609.321, subdivision 9~~ is a
132.19 sexually exploited youth;

132.20 (12) has committed a delinquent act or a juvenile petty offense before becoming
132.21 ten years old;

132.22 (13) is a runaway;

132.23 (14) is a habitual truant;

132.24 (15) has been found incompetent to proceed or has been found not guilty by reason
132.25 of mental illness or mental deficiency in connection with a delinquency proceeding, a
132.26 certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a
132.27 proceeding involving a juvenile petty offense; or

132.28 (16) has a parent whose parental rights to one or more other children were
132.29 involuntarily terminated or whose custodial rights to another child have been involuntarily
132.30 transferred to a relative and there is a case plan prepared by the responsible social services
132.31 agency documenting a compelling reason why filing the termination of parental rights
132.32 petition under section 260C.301, subdivision 3, is not in the best interests of the child; ~~or~~

132.33 ~~(17) is a sexually exploited youth.~~

132.34 **EFFECTIVE DATE.** This section is effective August 1, 2014.

132.35 Sec. 40. Minnesota Statutes 2012, section 260C.007, subdivision 31, is amended to read:

133.1 Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an
133.2 individual who:

133.3 (1) is alleged to have engaged in conduct which would, if committed by an adult,
133.4 violate any federal, state, or local law relating to being hired, offering to be hired, or
133.5 agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

133.6 (2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345,
133.7 609.3451, 609.3453, 609.352, 617.246, or 617.247;

133.8 (3) is a victim of a crime described in United States Code, title 18, section 2260;
133.9 2421; 2422; 2423; 2425; 2425A; or 2256; or

133.10 (4) is a sex trafficking victim as defined in section 609.321, subdivision 7b.

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

133.12 Sec. 41. Minnesota Statutes 2012, section 518A.60, is amended to read:

133.13 **518A.60 COLLECTION; ARREARS ONLY.**

133.14 (a) Remedies available for the collection and enforcement of support in this chapter
133.15 and chapters 256, 257, 518, and 518C also apply to cases in which the child or children
133.16 for whom support is owed are emancipated and the obligor owes past support or has an
133.17 accumulated arrearage as of the date of the youngest child's emancipation. Child support
133.18 arrearages under this section include arrearages for child support, medical support, child
133.19 care, pregnancy and birth expenses, and unreimbursed medical expenses as defined in
133.20 section 518A.41, subdivision 1, paragraph (h).

133.21 (b) This section applies retroactively to any support arrearage that accrued on or
133.22 before June 3, 1997, and to all arrearages accruing after June 3, 1997.

133.23 (c) Past support or pregnancy and confinement expenses ordered for which the
133.24 obligor has specific court ordered terms for repayment may not be enforced using
133.25 drivers' and occupational or professional license suspension, credit bureau reporting, and
133.26 additional income withholding under section 518A.53, subdivision 10, paragraph (a),
133.27 unless the obligor fails to comply with the terms of the court order for repayment.

133.28 (d) If an arrearage exists at the time a support order would otherwise terminate
133.29 and section 518A.53, subdivision 10, paragraph (c), does not apply to this section, the
133.30 arrearage shall be repaid in an amount equal to the current support order until all arrears
133.31 have been paid in full, absent a court order to the contrary.

133.32 (e) If an arrearage exists according to a support order which fails to establish a
133.33 monthly support obligation in a specific dollar amount, the public authority, if it provides
133.34 child support services, or the obligee, may establish a payment agreement which shall

134.1 equal what the obligor would pay for current support after application of section 518A.34,
134.2 plus an additional 20 percent of the current support obligation, until all arrears have been
134.3 paid in full. If the obligor fails to enter into or comply with a payment agreement, the
134.4 public authority, if it provides child support services, or the obligee, may move the district
134.5 court or child support magistrate, if section 484.702 applies, for an order establishing
134.6 repayment terms.

134.7 (f) If there is no longer a current support order because all of the children of the
134.8 order are emancipated, the public authority may discontinue child support services and
134.9 close its case under title IV-D of the Social Security Act if:

134.10 (1) the arrearage is under \$500; or

134.11 (2) the arrearage is considered unenforceable by the public authority because there
134.12 have been no collections for three years, and all administrative and legal remedies have
134.13 been attempted or are determined by the public authority to be ineffective because the
134.14 obligor is unable to pay, the obligor has no known income or assets, and there is no
134.15 reasonable prospect that the obligor will be able to pay in the foreseeable future.

134.16 (g) At least 60 calendar days before the discontinuation of services under paragraph
134.17 (f), the public authority must mail a written notice to the obligee and obligor at the
134.18 obligee's and obligor's last known addresses that the public authority intends to close the
134.19 child support enforcement case and explaining each party's rights. Seven calendar days
134.20 after the first notice is mailed, the public authority must mail a second notice under this
134.21 paragraph to the obligee.

134.22 (h) The case must be kept open if the obligee responds before case closure and
134.23 provides information that could reasonably lead to collection of arrears. If the case is
134.24 closed, the obligee may later request that the case be reopened by completing a new
134.25 application for services, if there is a change in circumstances that could reasonably lead to
134.26 the collection of arrears.

134.27 Sec. 42. Laws 1998, chapter 407, article 6, section 116, is amended to read:

134.28 Sec. 116. **EBT TRANSACTION COSTS; APPROVAL FROM LEGISLATURE.**

134.29 The commissioner of human services shall ~~request and receive approval from the~~
134.30 ~~legislature before adjusting the payment to~~ not subsidize retailers for electronic benefit
134.31 transfer ~~transaction costs~~ Supplemental Nutrition Assistance Program transactions.

134.32 **EFFECTIVE DATE.** This section is effective 30 days after the commissioner
134.33 notifies retailers of the termination of their agreement with the state. The commissioner of
134.34 human services must notify the revisor of statutes of that date.

135.1 Sec. 43. Laws 2011, First Special Session chapter 9, article 1, section 3, the effective
135.2 date, is amended to read:

135.3 **EFFECTIVE DATE.** This section is effective ~~January 1, 2013~~ July 1, 2014.

135.4 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2013.

135.5 Sec. 44. **DIRECTION TO COMMISSIONERS; INCOME AND ASSET**
135.6 **EXCLUSION.**

135.7 (a) The commissioner of human services shall not count conditional cash transfers
135.8 made to families participating in a family independence demonstration as income or
135.9 assets for purposes of determining or redetermining eligibility for child care assistance
135.10 programs under Minnesota Statutes, chapter 119B; general assistance under Minnesota
135.11 Statutes, chapter 256D; group residential housing under Minnesota Statutes, chapter 256I;
135.12 the Minnesota family investment program, work benefit program, or diversionary work
135.13 program under Minnesota Statutes, chapter 256J, during the duration of the demonstration.

135.14 (b) The commissioner of human services shall not count conditional cash transfers
135.15 made to families participating in a family independence demonstration as income or assets
135.16 for purposes of determining or redetermining eligibility for medical assistance under
135.17 Minnesota Statutes, chapter 256B, and MinnesotaCare under Minnesota Statutes, chapter
135.18 256L, except that for enrollees subject to a modified adjusted gross income calculation to
135.19 determine eligibility, the conditional cash transfer payments shall be counted as income if
135.20 they are included on the enrollee's federal tax return as income, or if the payments can be
135.21 taken into account in the month of receipt as a lump sum payment.

135.22 (c) The commissioner of the Minnesota Housing Finance Agency shall not count
135.23 conditional cash transfers made to families participating in a family independence
135.24 demonstration as income or assets for purposes of determining or redetermining eligibility
135.25 for housing assistance programs under Minnesota Statutes, section 462A.201, during
135.26 the duration of the demonstration.

135.27 (d) For the purposes of this section:

135.28 (1) "conditional cash transfer" means a payment made to a participant in a family
135.29 independence demonstration by a sponsoring organization to incent, support, or facilitate
135.30 participation; and

135.31 (2) "family independence demonstration" means an initiative sponsored or
135.32 cosponsored by a governmental or nongovernmental organization, the goal of which is
135.33 to facilitate individualized goal-setting and peer support for cohorts of no more than 12

136.1 families each toward the development of financial and nonfinancial assets that enable the
136.2 participating families to achieve financial independence.

136.3 (e) The citizens league shall provide a report to the legislative committees having
136.4 jurisdiction over human services issues by July 1, 2016, informing the legislature on the
136.5 progress and outcomes of the demonstration under this section.

136.6 **Sec. 45. REDUCTION OF YOUTH HOMELESSNESS.**

136.7 (a) The Minnesota Interagency Council on Homelessness established under the
136.8 authority of Minnesota Statutes, section 462A.29, as it updates its statewide plan to
136.9 prevent and end homelessness, shall make recommendations on strategies to reduce the
136.10 number of youth experiencing homelessness and to prevent homelessness for youth who
136.11 are at risk of becoming homeless.

136.12 (b) Recommended strategies must take into consideration, to the extent feasible,
136.13 issues that contribute to or reduce youth homelessness including, but not limited to, mental
136.14 health, chemical dependency, trafficking of youth for sex or other purposes, exiting foster
136.15 care, and involvement in gangs. The recommended strategies must include supportive
136.16 services as outlined in Minnesota Statutes, section 256K.45, subdivision 5.

136.17 (c) The council shall provide an update on the status of its work by December 1,
136.18 2014, to the legislative committees with jurisdiction over housing, homelessness, and
136.19 matters pertaining to youth. If the council determines legislative action is required to
136.20 implement recommended strategies, the council shall submit proposals to the legislature at
136.21 the earliest possible opportunity.

136.22 **Sec. 46. HOUSING ASSISTANCE GRANTS; FORECASTED PROGRAM.**

136.23 Beginning July 1, 2015, housing assistance grants under Minnesota Statutes, section
136.24 256J.35, paragraph (a), must be a forecasted program and the commissioner, with the
136.25 approval of the commissioner of management and budget, may transfer unencumbered
136.26 appropriation balances within fiscal years of each biennium with other forecasted
136.27 programs of the Department of Human Services. The commissioner shall inform the
136.28 chairs and ranking minority members of the senate Health and Human Services Finance
136.29 Division and the house of representatives Health and Human Services Finance committee
136.30 quarterly about transfers made under this provision.

136.31 **Sec. 47. PLAN FOR GROUP RESIDENTIAL HOUSING SPECIALTY RATE**
136.32 **AND BANKED BEDS.**

137.1 The commissioner of human services, in consultation with and cooperation of the
137.2 counties, shall review the statewide number and status of group residential housing beds
137.3 with rates in excess of the MSA equivalent rate, including banked supplemental service
137.4 rate beds. The commissioner shall study the type and amount of supplemental services
137.5 delivered or planned for development, and develop a plan for rate setting criteria and
137.6 an efficient use of these beds. The commissioner shall review the performance of all
137.7 programs that receive supplemental service rates. The plan must require that all beds
137.8 receiving supplemental service rates address critical service needs and must establish
137.9 quality performance requirements for beds receiving supplemental service rates. The
137.10 commissioner shall present the written plan no later than February 1, 2014, to the chairs
137.11 and ranking minority members of the house of representatives and senate finance and
137.12 policy committees and divisions with jurisdiction over the Department of Human Services.

137.13 Sec. 48. **REPEALER.**

137.14 (a) Minnesota Statutes 2012, section 256J.24, is repealed January 1, 2015.

137.15 (b) Minnesota Statutes 2012, section 609.093, is repealed effective the day following
137.16 final enactment.

ARTICLE 4

STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES

137.19 Section 1. Minnesota Statutes 2012, section 245.462, subdivision 20, is amended to read:

137.20 Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain
137.21 or a clinically significant disorder of thought, mood, perception, orientation, memory, or
137.22 behavior that is detailed in a diagnostic codes list published by the commissioner, and that
137.23 seriously limits a person's capacity to function in primary aspects of daily living such as
137.24 personal relations, living arrangements, work, and recreation.

137.25 (b) An "adult with acute mental illness" means an adult who has a mental illness that
137.26 is serious enough to require prompt intervention.

137.27 (c) For purposes of case management and community support services, a "person
137.28 with serious and persistent mental illness" means an adult who has a mental illness and
137.29 meets at least one of the following criteria:

137.30 (1) the adult has undergone two or more episodes of inpatient care for a mental
137.31 illness within the preceding 24 months;

137.32 (2) the adult has experienced a continuous psychiatric hospitalization or residential
137.33 treatment exceeding six months' duration within the preceding 12 months;

138.1 (3) the adult has been treated by a crisis team two or more times within the preceding
138.2 24 months;

138.3 (4) the adult:

138.4 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression,
138.5 schizoaffective disorder, or borderline personality disorder;

138.6 (ii) indicates a significant impairment in functioning; and

138.7 (iii) has a written opinion from a mental health professional, in the last three years,
138.8 stating that the adult is reasonably likely to have future episodes requiring inpatient or
138.9 residential treatment, of a frequency described in clause (1) or (2), unless ongoing case
138.10 management or community support services are provided;

138.11 (5) the adult has, in the last three years, been committed by a court as a person who is
138.12 mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; ~~or~~

138.13 (6) the adult (i) was eligible under clauses (1) to (5), but the specified time period
138.14 has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and

138.15 (ii) has a written opinion from a mental health professional, in the last three years, stating
138.16 that the adult is reasonably likely to have future episodes requiring inpatient or residential
138.17 treatment, of a frequency described in clause (1) or (2), unless ongoing case management
138.18 or community support services are provided; or

138.19 (7) the adult was eligible as a child under section 245.4871, subdivision 6, and is
138.20 age 21 or younger.

138.21 Sec. 2. Minnesota Statutes 2012, section 245.4661, subdivision 5, is amended to read:

138.22 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with
138.23 the exception of the placement of a Minnesota specialty treatment facility as defined in
138.24 paragraph (c), must be developed under the direction of the county board, or multiple
138.25 county boards acting jointly, as the local mental health authority. The planning process
138.26 for each pilot shall include, but not be limited to, mental health consumers, families,
138.27 advocates, local mental health advisory councils, local and state providers, representatives
138.28 of state and local public employee bargaining units, and the department of human services.
138.29 As part of the planning process, the county board or boards shall designate a managing
138.30 entity responsible for receipt of funds and management of the pilot project.

138.31 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a
138.32 request for proposal for regions in which a need has been identified for services.

138.33 (c) For purposes of this section, "Minnesota specialty treatment facility" is defined
138.34 as an intensive rehabilitative mental health service under section 256B.0622, subdivision
138.35 2, paragraph (b).

139.1 Sec. 3. Minnesota Statutes 2012, section 245.4661, subdivision 6, is amended to read:

139.2 Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the
139.3 commissioner shall facilitate integration of funds or other resources as needed and
139.4 requested by each project. These resources may include:

139.5 (1) residential services funds administered under Minnesota Rules, parts 9535.2000
139.6 to 9535.3000, in an amount to be determined by mutual agreement between the project's
139.7 managing entity and the commissioner of human services after an examination of the
139.8 county's historical utilization of facilities located both within and outside of the county
139.9 and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

139.10 (2) community support services funds administered under Minnesota Rules, parts
139.11 9535.1700 to 9535.1760;

139.12 (3) other mental health special project funds;

139.13 (4) medical assistance, general assistance medical care, MinnesotaCare and group
139.14 residential housing if requested by the project's managing entity, and if the commissioner
139.15 determines this would be consistent with the state's overall health care reform efforts; and

139.16 (5) regional treatment center resources consistent with section 246.0136, subdivision
139.17 1-; and

139.18 (6) funds transferred from section 246.18, subdivision 8, for grants to providers to
139.19 participate in mental health specialty treatment services, awarded to providers through
139.20 a request for proposal process.

139.21 (b) The commissioner shall consider the following criteria in awarding start-up and
139.22 implementation grants for the pilot projects:

139.23 (1) the ability of the proposed projects to accomplish the objectives described in
139.24 subdivision 2;

139.25 (2) the size of the target population to be served; and

139.26 (3) geographical distribution.

139.27 (c) The commissioner shall review overall status of the projects initiatives at least
139.28 every two years and recommend any legislative changes needed by January 15 of each
139.29 odd-numbered year.

139.30 (d) The commissioner may waive administrative rule requirements which are
139.31 incompatible with the implementation of the pilot project.

139.32 (e) The commissioner may exempt the participating counties from fiscal sanctions
139.33 for noncompliance with requirements in laws and rules which are incompatible with the
139.34 implementation of the pilot project.

139.35 (f) The commissioner may award grants to an entity designated by a county board or
139.36 group of county boards to pay for start-up and implementation costs of the pilot project.

140.1 Sec. 4. Minnesota Statutes 2012, section 245.4682, subdivision 2, is amended to read:

140.2 Subd. 2. **General provisions.** (a) In the design and implementation of reforms to
140.3 the mental health system, the commissioner shall:

140.4 (1) consult with consumers, families, counties, tribes, advocates, providers, and
140.5 other stakeholders;

140.6 (2) bring to the legislature, and the State Advisory Council on Mental Health, by
140.7 January 15, 2008, recommendations for legislation to update the role of counties and to
140.8 clarify the case management roles, functions, and decision-making authority of health
140.9 plans and counties, and to clarify county retention of the responsibility for the delivery of
140.10 social services as required under subdivision 3, paragraph (a);

140.11 (3) withhold implementation of any recommended changes in case management
140.12 roles, functions, and decision-making authority until after the release of the report due
140.13 January 15, 2008;

140.14 (4) ensure continuity of care for persons affected by these reforms including
140.15 ensuring client choice of provider by requiring broad provider networks and developing
140.16 mechanisms to facilitate a smooth transition of service responsibilities;

140.17 (5) provide accountability for the efficient and effective use of public and private
140.18 resources in achieving positive outcomes for consumers;

140.19 (6) ensure client access to applicable protections and appeals; and

140.20 (7) make budget transfers necessary to implement the reallocation of services and
140.21 client responsibilities between counties and health care programs that do not increase the
140.22 state and county costs and efficiently allocate state funds.

140.23 (b) When making transfers under paragraph (a) necessary to implement movement
140.24 of responsibility for clients and services between counties and health care programs,
140.25 the commissioner, in consultation with counties, shall ensure that any transfer of state
140.26 grants to health care programs, including the value of case management transfer grants
140.27 under section 256B.0625, subdivision 20, does not exceed the value of the services being
140.28 transferred for the latest 12-month period for which data is available. The commissioner
140.29 may make quarterly adjustments based on the availability of additional data during the
140.30 first four quarters after the transfers first occur. If case management transfer grants under
140.31 section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior
140.32 to repeal, exceeds the value of the services being transferred, the difference becomes an
140.33 ongoing part of each county's adult and children's mental health grants under sections
140.34 245.4661, ~~245.4889~~, and 256E.12.

140.35 (c) This appropriation is not authorized to be expended after December 31, 2010,
140.36 unless approved by the legislature.

141.1 Sec. 5. Minnesota Statutes 2012, section 245.4871, subdivision 26, is amended to read:

141.2 Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a person
141.3 providing services to children with emotional disturbances. A mental health practitioner
141.4 must have training and experience in working with children. A mental health practitioner
141.5 must be qualified in at least one of the following ways:

141.6 (1) holds a bachelor's degree in one of the behavioral sciences or related fields from
141.7 an accredited college or university and:

141.8 (i) has at least 2,000 hours of supervised experience in the delivery of mental health
141.9 services to children with emotional disturbances; or

141.10 (ii) is fluent in the non-English language of the ethnic group to which at least 50
141.11 percent of the practitioner's clients belong, completes 40 hours of training in the delivery
141.12 of services to children with emotional disturbances, and receives clinical supervision from
141.13 a mental health professional at least once a week until the requirement of 2,000 hours
141.14 of supervised experience is met;

141.15 (2) has at least 6,000 hours of supervised experience in the delivery of mental
141.16 health services to children with emotional disturbances; hours worked as a mental health
141.17 behavioral aide I or II under section 256B.0943, subdivision 7, may be included in the
141.18 6,000 hours of experience;

141.19 (3) is a graduate student in one of the behavioral sciences or related fields and is
141.20 formally assigned by an accredited college or university to an agency or facility for
141.21 clinical training; or

141.22 (4) holds a master's or other graduate degree in one of the behavioral sciences or
141.23 related fields from an accredited college or university ~~and has less than 4,000 hours~~
141.24 ~~post-master's experience in the treatment of emotional disturbance.~~

141.25 Sec. 6. Minnesota Statutes 2012, section 245.4875, subdivision 8, is amended to read:

141.26 Subd. 8. **Transition services.** The county board may continue to provide mental
141.27 health services as defined in sections 245.487 to 245.4889 to persons over 18 years of
141.28 age, but under 21 years of age, if the person was receiving case management or family
141.29 community support services prior to age 18, and if one of the following conditions is met:

141.30 (1) the person is receiving special education services through the local school
141.31 district; ~~or~~

141.32 (2) it is in the best interest of the person to continue services defined in sections
141.33 245.487 to 245.4889; or

141.34 (3) the person is requesting services and the services are medically necessary.

142.1 Sec. 7. Minnesota Statutes 2012, section 245.4881, subdivision 1, is amended to read:

142.2 Subdivision 1. **Availability of case management services.** (a) The county board
142.3 shall provide case management services for each child with severe emotional disturbance
142.4 who is a resident of the county and the child's family who request or consent to the services.
142.5 Case management services ~~may be continued~~ must be offered to be provided for a child with
142.6 a serious emotional disturbance who is over the age of 18 consistent with section 245.4875,
142.7 subdivision 8, or the child's legal representative, provided the child's service needs can be
142.8 met within the children's service system. Before discontinuing case management services
142.9 under this subdivision for children between the ages of 17 and 21, a transition plan
142.10 must be developed. The transition plan must be developed with the child and, with the
142.11 consent of a child age 18 or over, the child's parent, guardian, or legal representative. The
142.12 transition plan should include plans for health insurance, housing, education, employment,
142.13 and treatment. Staffing ratios must be sufficient to serve the needs of the clients. The case
142.14 manager must meet the requirements in section 245.4871, subdivision 4.

142.15 (b) Except as permitted by law and the commissioner under demonstration projects,
142.16 case management services provided to children with severe emotional disturbance eligible
142.17 for medical assistance must be billed to the medical assistance program under sections
142.18 256B.02, subdivision 8, and 256B.0625.

142.19 (c) Case management services are eligible for reimbursement under the medical
142.20 assistance program. Costs of mentoring, supervision, and continuing education may be
142.21 included in the reimbursement rate methodology used for case management services under
142.22 the medical assistance program.

142.23 Sec. 8. Minnesota Statutes 2012, section 246.18, subdivision 8, is amended to read:

142.24 Subd. 8. **State-operated services account.** (a) The state-operated services account is
142.25 established in the special revenue fund. Revenue generated by new state-operated services
142.26 listed under this section established after July 1, 2010, that are not enterprise activities must
142.27 be deposited into the state-operated services account, unless otherwise specified in law:

- 142.28 (1) intensive residential treatment services;
142.29 (2) foster care services; and
142.30 (3) psychiatric extensive recovery treatment services.

142.31 (b) Funds deposited in the state-operated services account are available to the
142.32 commissioner of human services for the purposes of:

- 142.33 (1) providing services needed to transition individuals from institutional settings
142.34 within state-operated services to the community when those services have no other
142.35 adequate funding source;

143.1 (2) grants to providers participating in mental health specialty treatment services
143.2 under section 245.4661; and

143.3 (3) to fund the operation of the Intensive Residential Treatment Service program in
143.4 Willmar.

143.5 Sec. 9. Minnesota Statutes 2012, section 246.18, is amended by adding a subdivision
143.6 to read:

143.7 Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds
143.8 to the account in subdivision 8 for noncovered allowable costs of a provider certified and
143.9 licensed under section 256B.0622 and operating under section 246.014.

143.10 Sec. 10. Minnesota Statutes 2012, section 246.54, is amended to read:

143.11 **246.54 LIABILITY OF COUNTY; REIMBURSEMENT.**

143.12 Subdivision 1. **County portion for cost of care.** (a) Except for chemical
143.13 dependency services provided under sections 254B.01 to 254B.09, the client's county
143.14 shall pay to the state of Minnesota a portion of the cost of care provided in a regional
143.15 treatment center or a state nursing facility to a client legally settled in that county. A
143.16 county's payment shall be made from the county's own sources of revenue and payments
143.17 shall equal a percentage of the cost of care, as determined by the commissioner, for each
143.18 day, or the portion thereof, that the client spends at a regional treatment center or a state
143.19 nursing facility according to the following schedule:

- 143.20 (1) zero percent for the first 30 days;
143.21 (2) 20 percent for days 31 to 60; and
143.22 (3) ~~50~~ 75 percent for any days over 60.

143.23 (b) The increase in the county portion for cost of care under paragraph (a), clause
143.24 (3), shall be imposed when the treatment facility has determined that it is clinically
143.25 appropriate for the client to be discharged.

143.26 (c) If payments received by the state under sections 246.50 to 246.53 exceed 80
143.27 percent of the cost of care for days 31 to 60, or ~~50~~ 25 percent for days over 60, the county
143.28 shall be responsible for paying the state only the remaining amount. The county shall
143.29 not be entitled to reimbursement from the client, the client's estate, or from the client's
143.30 relatives, except as provided in section 246.53.

143.31 Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the
143.32 Minnesota Security Hospital ~~or the Minnesota extended treatment options program.~~ For
143.33 services at ~~these facilities~~ the Minnesota Security Hospital, a county's payment shall be
143.34 made from the county's own sources of revenue and payments ~~shall be paid as follows:~~

144.1 Excluding the state-operated forensic transition service, payments to the state from the
144.2 county shall equal ten percent of the cost of care, as determined by the commissioner, for
144.3 each day, or the portion thereof, that the client spends at the facility. For the state-operated
144.4 forensic transition service, payments to the state from the county shall equal 50 percent of
144.5 the cost of care, as determined by the commissioner, for each day, or the portion thereof,
144.6 that the client spends in the program. If payments received by the state under sections
144.7 246.50 to 246.53 for services provided at the Minnesota Security Hospital, excluding the
144.8 state-operated forensic transition service, exceed 90 percent of the cost of care, the county
144.9 shall be responsible for paying the state only the remaining amount. If payments received
144.10 by the state under sections 246.50 to 246.53 for the state-operated forensic transition service
144.11 exceed 50 percent of the cost of care, the county shall be responsible for paying the state
144.12 only the remaining amount. The county shall not be entitled to reimbursement from the
144.13 client, the client's estate, or from the client's relatives, except as provided in section 246.53.

144.14 (b) Regardless of the facility to which the client is committed, subdivision 1 does
144.15 not apply to the following individuals:

144.16 ~~(1) clients who are committed as mentally ill and dangerous under section 253B.02,~~
144.17 ~~subdivision 17;~~

144.18 ~~(2) (1) clients who are committed as sexual psychopathic personalities under section~~
144.19 ~~253B.02, subdivision 18b; and~~

144.20 ~~(3) (2) clients who are committed as sexually dangerous persons under section~~
144.21 ~~253B.02, subdivision 18c.~~

144.22 ~~For each of the individuals in clauses (1) to (3), the payment by the county to the state~~
144.23 ~~shall equal ten percent of the cost of care for each day as determined by the commissioner.~~

144.24 Sec. 11. Minnesota Statutes 2012, section 253B.10, subdivision 1, is amended to read:

144.25 Subdivision 1. **Administrative requirements.** (a) When a person is committed,
144.26 the court shall issue a warrant or an order committing the patient to the custody of the
144.27 head of the treatment facility. The warrant or order shall state that the patient meets the
144.28 statutory criteria for civil commitment.

144.29 (b) The commissioner shall prioritize patients being admitted from jail or a
144.30 correctional institution who are:

144.31 (1) ordered confined in a state hospital for an examination under Minnesota Rules of
144.32 Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

144.33 (2) under civil commitment for competency treatment and continuing supervision
144.34 under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

145.1 (3) found not guilty by reason of mental illness under Minnesota Rules of Criminal
145.2 Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be
145.3 detained in a state hospital or other facility pending completion of the civil commitment
145.4 proceedings; or

145.5 (4) committed under this chapter to the commissioner after dismissal of the patient's
145.6 criminal charges.

145.7 Patients described in this paragraph must be admitted to a service operated by the
145.8 commissioner within 48 hours. The commitment must be ordered by the court as provided
145.9 in section 253B.09, subdivision 1, paragraph (c).

145.10 (c) Upon the arrival of a patient at the designated treatment facility, the head of the
145.11 facility shall retain the duplicate of the warrant and endorse receipt upon the original
145.12 warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment
145.13 must be filed in the court of commitment. After arrival, the patient shall be under the
145.14 control and custody of the head of the treatment facility.

145.15 (d) Copies of the petition for commitment, the court's findings of fact and
145.16 conclusions of law, the court order committing the patient, the report of the examiners,
145.17 and the prepetition report shall be provided promptly to the treatment facility.

145.18 Sec. 12. Minnesota Statutes 2012, section 254B.13, is amended to read:

145.19 **254B.13 PILOT PROJECTS; CHEMICAL HEALTH CARE.**

145.20 Subdivision 1. **Authorization for navigator pilot projects.** The commissioner may
145.21 approve and implement navigator pilot projects developed under the planning process
145.22 required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and
145.23 enhance coordination of the delivery of chemical health services required under section
145.24 254B.03.

145.25 Subd. 2. **Program design and implementation.** (a) The commissioner and
145.26 counties participating in the navigator pilot projects shall continue to work in partnership
145.27 to refine and implement the navigator pilot projects initiated under Laws 2009, chapter
145.28 79, article 7, section 26.

145.29 (b) The commissioner and counties participating in the navigator pilot projects shall
145.30 complete the planning phase ~~by June 30, 2010~~, and, if approved by the commissioner for
145.31 implementation, enter into agreements governing the operation of the navigator pilot
145.32 projects ~~with implementation scheduled no earlier than July 1, 2010.~~

145.33 **Subd. 2a. Eligibility for navigator pilot program.** (a) To be considered for
145.34 participation in a navigator pilot program, an individual must:

145.35 (1) be a resident of a county with an approved navigator program;

- 146.1 (2) be eligible for consolidated chemical dependency treatment fund services;
146.2 (3) be a voluntary participant in the navigator program;
146.3 (4) satisfy one of the following items:
146.4 (i) have at least one severity rating of three or above in dimension four, five, or six in
146.5 a comprehensive assessment under Minnesota Rules, part 9530.6422; or
146.6 (ii) have at least one severity rating of two or above in dimension four, five, or six in
146.7 a comprehensive assessment under Minnesota Rules, part 9530.6422, and be currently
146.8 participating in a Rule 31 treatment program under Minnesota Rules, parts 9530.6405 to
146.9 9530.6505, or be within 60 days following discharge after participation in a Rule 31
146.10 treatment program; and
146.11 (5) have had at least two treatment episodes in the past two years, not limited
146.12 to episodes reimbursed by the consolidated chemical dependency treatment funds. An
146.13 admission to an emergency room, a detoxification program, or a hospital may be substituted
146.14 for one treatment episode if it resulted from the individual's substance use disorder.
146.15 (b) New eligibility criteria may be added as mutually agreed upon by the
146.16 commissioner and participating navigator programs.

146.17 Subd. 3. **Program evaluation.** The commissioner shall evaluate navigator pilot
146.18 projects under this section and report the results of the evaluation to the chairs and
146.19 ranking minority members of the legislative committees with jurisdiction over chemical
146.20 health issues by January 15, 2014. Evaluation of the navigator pilot projects must be
146.21 based on outcome evaluation criteria negotiated with the navigator pilot projects prior
146.22 to implementation.

146.23 Subd. 4. **Notice of navigator pilot project discontinuation.** Each county's
146.24 participation in the navigator pilot project may be discontinued for any reason by the county
146.25 or the commissioner of human services after 30 days' written notice to the other party.
146.26 ~~Any unspent funds held for the exiting county's pro rata share in the special revenue fund~~
146.27 ~~under the authority in subdivision 5, paragraph (d), shall be transferred to the consolidated~~
146.28 ~~chemical dependency treatment fund following discontinuation of the pilot project.~~

146.29 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in
146.30 this chapter, the commissioner may authorize navigator pilot projects to use chemical
146.31 dependency treatment funds to pay for nontreatment navigator pilot services:

146.32 (1) in addition to those authorized under section 254B.03, subdivision 2, paragraph
146.33 (a); and

146.34 (2) by vendors in addition to those authorized under section 254B.05 when not
146.35 providing chemical dependency treatment services.

147.1 (b) For purposes of this section, "nontreatment navigator pilot services" include
147.2 navigator services, peer support, family engagement and support, housing support, rent
147.3 subsidies, supported employment, and independent living skills.

147.4 (c) State expenditures for chemical dependency services and nontreatment navigator
147.5 pilot services provided by or through the navigator pilot projects must not be greater than
147.6 the chemical dependency treatment fund expected share of forecasted expenditures in the
147.7 absence of the navigator pilot projects. The commissioner may restructure the schedule of
147.8 payments between the state and participating counties under the local agency share and
147.9 division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to
147.10 facilitate the operation of the navigator pilot projects.

147.11 ~~(d) To the extent that state fiscal year expenditures within a pilot project are less~~
147.12 ~~than the expected share of forecasted expenditures in the absence of the pilot projects,~~
147.13 ~~the commissioner shall deposit the unexpended funds in a separate account within the~~
147.14 ~~consolidated chemical dependency treatment fund, and make these funds available for~~
147.15 ~~expenditure by the pilot projects the following year. To the extent that treatment and~~
147.16 ~~nontreatment pilot services expenditures within the pilot project exceed the amount~~
147.17 ~~expected in the absence of the pilot projects, the pilot project county or counties are~~
147.18 ~~responsible for the portion of nontreatment pilot services expenditures in excess of the~~
147.19 ~~otherwise expected share of forecasted expenditures.~~

147.20 ~~(e)~~ (d) The commissioner may waive administrative rule requirements that are
147.21 incompatible with the implementation of the navigator pilot project, except that any
147.22 chemical dependency treatment funded under this section must continue to be provided
147.23 by a licensed treatment provider.

147.24 ~~(f)~~ (e) The commissioner shall not approve or enter into any agreement related to
147.25 navigator pilot projects authorized under this section that puts current or future federal
147.26 funding at risk.

147.27 (f) The commissioner shall provide participating navigator pilot projects with
147.28 transactional data, reports, provider data, and other data generated by county activity to
147.29 assess and measure outcomes. This information must be transmitted or made available in
147.30 an acceptable form to participating navigator pilot projects at least once every six months
147.31 or within a reasonable time following the commissioner's receipt of information from the
147.32 counties needed to comply with this paragraph.

147.33 Subd. 6. **Duties of county board.** The county board, or other county entity that
147.34 is approved to administer a navigator pilot project, shall:

147.35 (1) administer the navigator pilot project in a manner consistent with the objectives
147.36 described in subdivision 2 and the planning process in subdivision 5;

148.1 (2) ensure that no one is denied chemical dependency treatment services for which
148.2 they would otherwise be eligible under section 254A.03, subdivision 3; and

148.3 (3) provide the commissioner with timely and pertinent information as negotiated in
148.4 agreements governing operation of the navigator pilot projects.

148.5 Subd. 7. **Managed care.** An individual who is eligible for the navigator pilot
148.6 program under subdivision 2a is excluded from mandatory enrollment in managed care
148.7 until these services are included in the health plan's benefit set.

148.8 Subd. 8. **Authorization for continuation of navigator pilots.** The navigator pilot
148.9 projects implemented pursuant to subdivision 1 are authorized to continue operation after
148.10 July 1, 2013, under existing agreements governing operation of the pilot projects.

148.11 **EFFECTIVE DATE.** The amendments to subdivisions 1 to 6 and 8 are effective
148.12 August 1, 2013. Subdivision 7 is effective July 1, 2013.

148.13 Sec. 13. **[254B.14] CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL**
148.14 **HEALTH CARE.**

148.15 Subdivision 1. **Authorization for continuum of care pilot projects.** The
148.16 commissioner shall establish chemical dependency continuum of care pilot projects to
148.17 begin implementing the measures developed with stakeholder input and identified in the
148.18 report completed pursuant to Laws 2012, chapter 247, article 5, section 8. The pilot
148.19 projects are intended to improve the effectiveness and efficiency of the service continuum
148.20 for chemically dependent individuals in Minnesota while reducing duplication of efforts
148.21 and promoting scientifically supported practices.

148.22 Subd. 2. **Program implementation.** (a) The commissioner, in coordination with
148.23 representatives of the Minnesota Association of County Social Service Administrators
148.24 and the Minnesota Inter-County Association, shall develop a process for identifying and
148.25 selecting interested counties and providers for participation in the continuum of care pilot
148.26 projects. There shall be three pilot projects; one representing the northern region, one for
148.27 the metro region, and one for the southern region. The selection process of counties and
148.28 providers must include consideration of population size, geographic distribution, cultural
148.29 and racial demographics, and provider accessibility. The commissioner shall identify
148.30 counties and providers that are selected for participation in the continuum of care pilot
148.31 projects no later than September 30, 2013.

148.32 (b) The commissioner and entities participating in the continuum of care pilot
148.33 projects shall enter into agreements governing the operation of the continuum of care pilot
148.34 projects. The agreements shall identify pilot project outcomes and include timelines for
148.35 implementation and beginning operation of the pilot projects.

149.1 (c) Entities that are currently participating in the navigator pilot project are
149.2 eligible to participate in the continuum of care pilot project subsequent to or instead of
149.3 participating in the navigator pilot project.

149.4 (d) The commissioner may waive administrative rule requirements that are
149.5 incompatible with implementation of the continuum of care pilot projects.

149.6 (e) Notwithstanding section 254A.19, the commissioner may designate noncounty
149.7 entities to complete chemical use assessments and placement authorizations required
149.8 under section 254A.19 and Minnesota Rules, parts 9530.6600 to 9530.6655. Section
149.9 254A.19, subdivision 3, is applicable to the continuum of care pilot projects at the
149.10 discretion of the commissioner.

149.11 Subd. 3. **Program design.** (a) The operation of the pilot projects shall include:

149.12 (1) new services that are responsive to the chronic nature of substance use disorder;

149.13 (2) telehealth services, when appropriate to address barriers to services;

149.14 (3) services that assure integration with the mental health delivery system when
149.15 appropriate;

149.16 (4) services that address the needs of diverse populations; and

149.17 (5) an assessment and access process that permits clients to present directly to a
149.18 service provider for a substance use disorder assessment and authorization of services.

149.19 (b) Prior to implementation of the continuum of care pilot projects, a utilization
149.20 review process must be developed and agreed to by the commissioner, participating
149.21 counties, and providers. The utilization review process shall be described in the
149.22 agreements governing operation of the continuum of care pilot projects.

149.23 Subd. 4. **Notice of project discontinuation.** Each entity's participation in the
149.24 continuum of care pilot project may be discontinued for any reason by the county or the
149.25 commissioner after 30 days' written notice to the entity.

149.26 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this
149.27 chapter, the commissioner may authorize chemical dependency treatment funds to pay for
149.28 nontreatment services arranged by continuum of care pilot projects. Individuals who are
149.29 currently accessing Rule 31 treatment services are eligible for concurrent participation in
149.30 the continuum of care pilot projects.

149.31 (b) County expenditures for continuum of care pilot project services shall not
149.32 be greater than their expected share of forecasted expenditures in the absence of the
149.33 continuum of care pilot projects.

149.34 Subd. 6. **Managed care.** An individual who is eligible for the continuum of care
149.35 pilot project is excluded from mandatory enrollment in managed care unless these services
149.36 are included in the health plan's benefit set.

150.1 **EFFECTIVE DATE.** This section is effective August 1, 2013.

150.2 Sec. 14. **[256.478] HOME AND COMMUNITY-BASED SERVICES**
150.3 **TRANSITIONS GRANTS.**

150.4 (a) The commissioner shall make available home and community-based services
150.5 transition grants to serve individuals who do not meet eligibility criteria for the medical
150.6 assistance program under section 256B.056 or 256B.057, but who otherwise meet the
150.7 criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

150.8 (b) For the purposes of this section, the commissioner has the authority to transfer
150.9 funds between the medical assistance account and the home and community-based
150.10 services transitions grants account.

150.11 **EFFECTIVE DATE.** This section is effective July 1, 2013.

150.12 Sec. 15. **[256B.0616] MENTAL HEALTH CERTIFIED FAMILY PEER**
150.13 **SPECIALIST.**

150.14 Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer
150.15 specialists services, as established in subdivision 2, subject to federal approval, if provided
150.16 to recipients who have an emotional disturbance or severe emotional disturbance under
150.17 chapter 245, and are provided by a certified family peer specialist who has completed the
150.18 training under subdivision 5. A family peer specialist cannot provide services to the
150.19 peer specialist's family.

150.20 Subd. 2. **Establishment.** The commissioner of human services shall establish a
150.21 certified family peer specialists program model which:

150.22 (1) provides nonclinical family peer support counseling, building on the strengths
150.23 of families and helping them achieve desired outcomes;

150.24 (2) collaborates with others providing care or support to the family;

150.25 (3) provides nonadversarial advocacy;

150.26 (4) promotes the individual family culture in the treatment milieu;

150.27 (5) links parents to other parents in the community;

150.28 (6) offers support and encouragement;

150.29 (7) assists parents in developing coping mechanisms and problem-solving skills;

150.30 (8) promotes resiliency, self-advocacy, development of natural supports, and
150.31 maintenance of skills learned in other support services;

150.32 (9) establishes and provides peer led parent support groups; and

151.1 (10) increases the child's ability to function better within the child's home, school,
151.2 and community by educating parents on community resources, assisting with problem
151.3 solving, and educating parents on mental illnesses.

151.4 Subd. 3. **Eligibility.** Family peer support services may be located in inpatient
151.5 hospitalization, partial hospitalization, residential treatment, treatment foster care, day
151.6 treatment, children's therapeutic services and supports, or crisis services.

151.7 Subd. 4. **Peer support specialist program providers.** The commissioner shall
151.8 develop a process to certify family peer support specialist programs, in accordance with
151.9 the federal guidelines, in order for the program to bill for reimbursable services. Family
151.10 peer support programs must operate within an existing mental health community provider
151.11 or center.

151.12 Subd. 5. **Certified family peer specialist training and certification.** The
151.13 commissioner shall develop a training and certification process for certified family peer
151.14 specialists who must be at least 21 years of age and have a high school diploma or its
151.15 equivalent. The candidates must have raised or are currently raising a child with a mental
151.16 illness, have had experience navigating the children's mental health system, and must
151.17 demonstrate leadership and advocacy skills and a strong dedication to family-driven and
151.18 family-focused services. The training curriculum must teach participating family peer
151.19 specialists specific skills relevant to providing peer support to other parents. In addition
151.20 to initial training and certification, the commissioner shall develop ongoing continuing
151.21 educational workshops on pertinent issues related to family peer support counseling.

151.22 Sec. 16. Minnesota Statutes 2012, section 256B.0623, subdivision 2, is amended to read:

151.23 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
151.24 meanings given them.

151.25 (a) "Adult rehabilitative mental health services" means mental health services
151.26 which are rehabilitative and enable the recipient to develop and enhance psychiatric
151.27 stability, social competencies, personal and emotional adjustment, ~~and~~ independent living,
151.28 parenting skills, and community skills, when these abilities are impaired by the symptoms
151.29 of mental illness. Adult rehabilitative mental health services are also appropriate when
151.30 provided to enable a recipient to retain stability and functioning, if the recipient would
151.31 be at risk of significant functional decompensation or more restrictive service settings
151.32 without these services.

151.33 (1) Adult rehabilitative mental health services instruct, assist, and support the
151.34 recipient in areas such as: interpersonal communication skills, community resource
151.35 utilization and integration skills, crisis assistance, relapse prevention skills, health care

152.1 directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking
152.2 and nutrition skills, transportation skills, medication education and monitoring, mental
152.3 illness symptom management skills, household management skills, employment-related
152.4 skills, parenting skills, and transition to community living services.

152.5 (2) These services shall be provided to the recipient on a one-to-one basis in the
152.6 recipient's home or another community setting or in groups.

152.7 (b) "Medication education services" means services provided individually or in
152.8 groups which focus on educating the recipient about mental illness and symptoms; the role
152.9 and effects of medications in treating symptoms of mental illness; and the side effects of
152.10 medications. Medication education is coordinated with medication management services
152.11 and does not duplicate it. Medication education services are provided by physicians,
152.12 pharmacists, physician's assistants, or registered nurses.

152.13 (c) "Transition to community living services" means services which maintain
152.14 continuity of contact between the rehabilitation services provider and the recipient and
152.15 which facilitate discharge from a hospital, residential treatment program under Minnesota
152.16 Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community
152.17 living services are not intended to provide other areas of adult rehabilitative mental health
152.18 services.

152.19 Sec. 17. Minnesota Statutes 2012, section 256B.0625, subdivision 48, is amended to
152.20 read:

152.21 Subd. 48. **Psychiatric consultation to primary care practitioners.** Effective
152.22 ~~January 1, 2006~~, Medical assistance covers consultation provided by a psychiatrist, a
152.23 psychologist, or an advanced practice registered nurse certified in psychiatric mental
152.24 health via telephone, e-mail, facsimile, or other means of communication to primary care
152.25 practitioners, including pediatricians. The need for consultation and the receipt of the
152.26 consultation must be documented in the patient record maintained by the primary care
152.27 practitioner. If the patient consents, and subject to federal limitations and data privacy
152.28 provisions, the consultation may be provided without the patient present.

152.29 Sec. 18. Minnesota Statutes 2012, section 256B.0625, subdivision 56, is amended to
152.30 read:

152.31 Subd. 56. **Medical service coordination.** (a)(1) Medical assistance covers in-reach
152.32 community-based service coordination that is performed through a hospital emergency
152.33 department as an eligible procedure under a state healthcare program for a frequent user.
152.34 A frequent user is defined as an individual who has frequented the hospital emergency

153.1 department for services three or more times in the previous four consecutive months.

153.2 In-reach community-based service coordination includes navigating services to address a
153.3 client's mental health, chemical health, social, economic, and housing needs, or any other
153.4 activity targeted at reducing the incidence of emergency room and other nonmedically
153.5 necessary health care utilization.

153.6 (2) Medical assistance covers in-reach community-based service coordination that
153.7 is performed through a hospital emergency department or inpatient psychiatric unit
153.8 for a child or young adult up to age 21 with a serious emotional disturbance who has
153.9 frequented the hospital emergency room two or more times in the previous consecutive
153.10 three months or been admitted to an inpatient psychiatric unit two or more times in the
153.11 previous consecutive four months, or is being discharged to a shelter.

153.12 (b) Reimbursement must be made in 15-minute increments and allowed for up to 60
153.13 days posthospital discharge based upon the specific identified emergency department visit
153.14 or inpatient admitting event. In-reach community-based service coordination shall seek to
153.15 connect frequent users with existing covered services available to them, including, but not
153.16 limited to, targeted case management, waiver case management, or care coordination in a
153.17 health care home. For children and young adults with a serious emotional disturbance,
153.18 in-reach community-based service coordination includes navigating and arranging for
153.19 community-based services prior to discharge to address a client's mental health, chemical
153.20 health, social, educational, family support and housing needs, or any other activity targeted
153.21 at reducing multiple incidents of emergency room use, inpatient readmissions, and other
153.22 nonmedically necessary health care utilization. In-reach services shall seek to connect
153.23 them with existing covered services, including targeted case management, waiver case
153.24 management, care coordination in a health care home, children's therapeutic services and
153.25 supports, crisis services, and respite care. Eligible in-reach service coordinators must hold
153.26 a minimum of a bachelor's degree in social work, public health, corrections, or a related
153.27 field. The commissioner shall submit any necessary application for waivers to the Centers
153.28 for Medicare and Medicaid Services to implement this subdivision.

153.29 (c)(1) For the purposes of this subdivision, "in-reach community-based service
153.30 coordination" means the practice of a community-based worker with training, knowledge,
153.31 skills, and ability to access a continuum of services, including housing, transportation,
153.32 chemical and mental health treatment, employment, education, and peer support services,
153.33 by working with an organization's staff to transition an individual back into the individual's
153.34 living environment. In-reach community-based service coordination includes working
153.35 with the individual during their discharge and for up to a defined amount of time in the
153.36 individual's living environment, reducing the individual's need for readmittance.

154.1 (2) Hospitals utilizing in-reach service coordinators shall report annually to the
154.2 commissioner on the number of adults, children, and adolescents served; the postdischarge
154.3 services which they accessed; and emergency department/psychiatric hospitalization
154.4 readmissions. The commissioner shall ensure that services and payments provided under
154.5 in-reach care coordination do not duplicate services or payments provided under section
154.6 256B.0753, 256B.0755, or 256B.0625, subdivision 20.

154.7 Sec. 19. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
154.8 subdivision to read:

154.9 Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon
154.10 federal approval, whichever is later, medical assistance covers family psychoeducation
154.11 services provided to a child up to age 21 with a diagnosed mental health condition when
154.12 identified in the child's individual treatment plan and provided by a licensed mental health
154.13 professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a
154.14 clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who
154.15 has determined it medically necessary to involve family members in the child's care. For
154.16 the purposes of this subdivision, "family psychoeducation services" means information
154.17 or demonstration provided to an individual or family as part of an individual, family,
154.18 multifamily group, or peer group session to explain, educate, and support the child and
154.19 family in understanding a child's symptoms of mental illness, the impact on the child's
154.20 development, and needed components of treatment and skill development so that the
154.21 individual, family, or group can help the child to prevent relapse, prevent the acquisition
154.22 of comorbid disorders, and achieve optimal mental health and long-term resilience.

154.23 Sec. 20. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
154.24 subdivision to read:

154.25 Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon
154.26 federal approval, whichever is later, medical assistance covers clinical care consultation
154.27 for a person up to age 21 who is diagnosed with a complex mental health condition or a
154.28 mental health condition that co-occurs with other complex and chronic conditions, when
154.29 described in the person's individual treatment plan and provided by a licensed mental health
154.30 professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical
154.31 trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes
154.32 of this subdivision, "clinical care consultation" means communication from a treating
154.33 mental health professional to other providers or educators not under the clinical supervision
154.34 of the treating mental health professional who are working with the same client to inform,

155.1 inquire, and instruct regarding the client's symptoms; strategies for effective engagement,
155.2 care, and intervention needs; and treatment expectations across service settings; and to
155.3 direct and coordinate clinical service components provided to the client and family.

155.4 Sec. 21. Minnesota Statutes 2012, section 256B.092, is amended by adding a
155.5 subdivision to read:

155.6 Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner
155.7 shall make available additional waiver allocations and additional necessary resources
155.8 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
155.9 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

155.10 (1) are otherwise eligible for the developmental disabilities waiver under this section;

155.11 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
155.12 the Minnesota Security Hospital;

155.13 (3) whose discharge would be significantly delayed without the available waiver
155.14 allocation; and

155.15 (4) who have met treatment objectives and no longer meet hospital level of care.

155.16 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
155.17 requirements of the federal approved waiver plan.

155.18 (c) Any corporate foster care home developed under this subdivision must be
155.19 considered an exception under section 245A.03, subdivision 7, paragraph (a).

155.20 **EFFECTIVE DATE.** This section is effective July 1, 2013.

155.21 Sec. 22. Minnesota Statutes 2012, section 256B.0943, subdivision 1, is amended to read:

155.22 Subdivision 1. **Definitions.** For purposes of this section, the following terms have
155.23 the meanings given them.

155.24 (a) "Children's therapeutic services and supports" means the flexible package of
155.25 mental health services for children who require varying therapeutic and rehabilitative
155.26 levels of intervention. The services are time-limited interventions that are delivered using
155.27 various treatment modalities and combinations of services designed to reach treatment
155.28 outcomes identified in the individual treatment plan.

155.29 (b) "Clinical supervision" means the overall responsibility of the mental health
155.30 professional for the control and direction of individualized treatment planning, service
155.31 delivery, and treatment review for each client. A mental health professional who is an
155.32 enrolled Minnesota health care program provider accepts full professional responsibility
155.33 for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,
155.34 and oversees or directs the supervisee's work.

156.1 (c) "County board" means the county board of commissioners or board established
156.2 under sections 402.01 to 402.10 or 471.59.

156.3 (d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

156.4 (e) "Culturally competent provider" means a provider who understands and can
156.5 utilize to a client's benefit the client's culture when providing services to the client. A
156.6 provider may be culturally competent because the provider is of the same cultural or
156.7 ethnic group as the client or the provider has developed the knowledge and skills through
156.8 training and experience to provide services to culturally diverse clients.

156.9 (f) "Day treatment program" for children means a site-based structured program
156.10 consisting of group psychotherapy for more than three individuals and other intensive
156.11 therapeutic services provided by a multidisciplinary team, under the clinical supervision
156.12 of a mental health professional.

156.13 (g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision
156.14 11.

156.15 (h) "Direct service time" means the time that a mental health professional, mental
156.16 health practitioner, or mental health behavioral aide spends face-to-face with a client
156.17 and the client's family. Direct service time includes time in which the provider obtains
156.18 a client's history or provides service components of children's therapeutic services and
156.19 supports. Direct service time does not include time doing work before and after providing
156.20 direct services, including scheduling, maintaining clinical records, consulting with others
156.21 about the client's mental health status, preparing reports, receiving clinical supervision,
156.22 and revising the client's individual treatment plan.

156.23 (i) "Direction of mental health behavioral aide" means the activities of a mental
156.24 health professional or mental health practitioner in guiding the mental health behavioral
156.25 aide in providing services to a client. The direction of a mental health behavioral aide
156.26 must be based on the client's individualized treatment plan and meet the requirements in
156.27 subdivision 6, paragraph (b), clause (5).

156.28 (j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
156.29 15. For persons at least age 18 but under age 21, mental illness has the meaning given in
156.30 section 245.462, subdivision 20, paragraph (a).

156.31 (k) "Individual behavioral plan" means a plan of intervention, treatment, and
156.32 services for a child written by a mental health professional or mental health practitioner,
156.33 under the clinical supervision of a mental health professional, to guide the work of the
156.34 mental health behavioral aide.

156.35 (l) "Individual treatment plan" has the meaning given in section 245.4871,
156.36 subdivision 21.

157.1 (m) "Mental health behavioral aide services" means medically necessary one-on-one
157.2 activities performed by a trained paraprofessional to assist a child retain or generalize
157.3 psychosocial skills as taught by a mental health professional or mental health practitioner
157.4 and as described in the child's individual treatment plan and individual behavior plan.
157.5 Activities involve working directly with the child or child's family as provided in
157.6 subdivision 9, paragraph (b), clause (4).

157.7 (n) "Mental health professional" means an individual as defined in section 245.4871,
157.8 subdivision 27, clauses (1) to (6), or tribal vendor as defined in section 256B.02,
157.9 subdivision 7, paragraph (b).

157.10 (o) "Mental health service plan development" includes:

157.11 (1) the development, review, and revision of a child's individual treatment plan,
157.12 as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of
157.13 the client or client's parents, primary caregiver, or other person authorized to consent to
157.14 mental health services for the client, and including arrangement of treatment and support
157.15 activities specified in the individual treatment plan; and

157.16 (2) administering standardized outcome measurement instruments, determined
157.17 and updated by the commissioner, as periodically needed to evaluate the effectiveness
157.18 of treatment for children receiving clinical services and reporting outcome measures,
157.19 as required by the commissioner.

157.20 ~~(p)~~ (p) "Preschool program" means a day program licensed under Minnesota Rules,
157.21 parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and
157.22 supports provider to provide a structured treatment program to a child who is at least 33
157.23 months old but who has not yet attended the first day of kindergarten.

157.24 ~~(q)~~ (q) "Skills training" means individual, family, or group training, delivered
157.25 by or under the direction of a mental health professional, designed to facilitate the
157.26 acquisition of psychosocial skills that are medically necessary to rehabilitate the child
157.27 to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric
157.28 illness or to self-monitor, compensate for, cope with, counteract, or replace skills deficits
157.29 or maladaptive skills acquired over the course of a psychiatric illness. Skills training
157.30 is subject to the following requirements:

157.31 (1) a mental health professional or a mental health practitioner must provide skills
157.32 training;

157.33 (2) the child must always be present during skills training; however, a brief absence
157.34 of the child for no more than ten percent of the session unit may be allowed to redirect or
157.35 instruct family members;

158.1 (3) skills training delivered to children or their families must be targeted to the
158.2 specific deficits or maladaptations of the child's mental health disorder and must be
158.3 prescribed in the child's individual treatment plan;

158.4 (4) skills training delivered to the child's family must teach skills needed by parents
158.5 to enhance the child's skill development and to help the child use in daily life the skills
158.6 previously taught by a mental health professional or mental health practitioner and to
158.7 develop or maintain a home environment that supports the child's progressive use skills;

158.8 (5) group skills training may be provided to multiple recipients who, because of the
158.9 nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from
158.10 interaction in a group setting, which must be staffed as follows:

158.11 (i) one mental health professional or one mental health practitioner under supervision
158.12 of a licensed mental health professional must work with a group of four to eight clients; or

158.13 (ii) two mental health professionals or two mental health practitioners under
158.14 supervision of a licensed mental health professional, or one professional plus one
158.15 practitioner must work with a group of nine to 12 clients.

158.16 Sec. 23. Minnesota Statutes 2012, section 256B.0943, subdivision 2, is amended to read:

158.17 Subd. 2. **Covered service components of children's therapeutic services and**
158.18 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary
158.19 children's therapeutic services and supports as defined in this section that an eligible
158.20 provider entity certified under subdivision 4 provides to a client eligible under subdivision
158.21 3.

158.22 (b) The service components of children's therapeutic services and supports are:

158.23 (1) individual, family, and group psychotherapy;

158.24 (2) individual, family, or group skills training provided by a mental health
158.25 professional or mental health practitioner;

158.26 (3) crisis assistance;

158.27 (4) mental health behavioral aide services; ~~and~~

158.28 (5) direction of a mental health behavioral aide; ~~;~~

158.29 (6) mental health service plan development;

158.30 (7) clinical care consultation under section 256B.0625, subdivision 62;

158.31 (8) family psychoeducation under section 256B.0625, subdivision 61; and

158.32 (9) services provided by a family peer specialist under section 256B.0616.

158.33 (c) Service components in paragraph (b) may be combined to constitute therapeutic
158.34 programs, including day treatment programs and therapeutic preschool programs.

159.1 Sec. 24. Minnesota Statutes 2012, section 256B.0943, subdivision 7, is amended to read:

159.2 Subd. 7. **Qualifications of individual and team providers.** (a) An individual
159.3 or team provider working within the scope of the provider's practice or qualifications
159.4 may provide service components of children's therapeutic services and supports that are
159.5 identified as medically necessary in a client's individual treatment plan.

159.6 (b) An individual provider must be qualified as:

159.7 (1) a mental health professional as defined in subdivision 1, paragraph (n); or

159.8 (2) a mental health practitioner as defined in section 245.4871, subdivision 26. The
159.9 mental health practitioner must work under the clinical supervision of a mental health
159.10 professional; or

159.11 (3) a mental health behavioral aide working under the clinical supervision of a
159.12 mental health professional to implement the rehabilitative mental health services identified
159.13 in the client's individual treatment plan and individual behavior plan.

159.14 (A) A level I mental health behavioral aide must:

159.15 (i) be at least 18 years old;

159.16 (ii) have a high school diploma or general equivalency diploma (GED) or two years
159.17 of experience as a primary caregiver to a child with severe emotional disturbance within
159.18 the previous ten years; and

159.19 (iii) meet preservice and continuing education requirements under subdivision 8.

159.20 (B) A level II mental health behavioral aide must:

159.21 (i) be at least 18 years old;

159.22 (ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering
159.23 clinical services in the treatment of mental illness concerning children or adolescents or
159.24 complete a certificate program established under subdivision 8a; and

159.25 (iii) meet preservice and continuing education requirements in subdivision 8.

159.26 (c) A preschool program multidisciplinary team must include at least one mental
159.27 health professional and one or more of the following individuals under the clinical
159.28 supervision of a mental health professional:

159.29 (i) a mental health practitioner; or

159.30 (ii) a program person, including a teacher, assistant teacher, or aide, who meets the
159.31 qualifications and training standards of a level I mental health behavioral aide.

159.32 (d) A day treatment multidisciplinary team must include at least one mental health
159.33 professional and one mental health practitioner.

159.34 Sec. 25. Minnesota Statutes 2012, section 256B.0943, is amended by adding a
159.35 subdivision to read:

160.1 Subd. 8a. Level II mental health behavioral aide. The commissioner of human
160.2 services, in collaboration with children's mental health providers and the Board of Trustees
160.3 of the Minnesota State Colleges and Universities, shall develop a certificate program
160.4 for level II mental health behavioral aides.

160.5 Sec. 26. Minnesota Statutes 2012, section 256B.0946, is amended to read:

160.6 **256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.**

160.7 Subdivision 1. **Required covered service components.** (a) Effective July 1, 2006,
160.8 upon enactment and subject to federal approval, medical assistance covers medically
160.9 necessary intensive treatment services described under paragraph (b) that are provided
160.10 by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2
160.11 who is placed in a ~~treatment~~ foster home licensed under Minnesota Rules, parts 2960.3000
160.12 to 2960.3340.

160.13 (b) Intensive treatment services to children with ~~severe emotional disturbance~~ mental
160.14 illness residing in ~~treatment foster care~~ family settings ~~must meet the relevant standards~~
160.15 ~~for mental health services under sections 245.487 to 245.4889. In addition, that comprise~~
160.16 specific required service components provided in clauses (1) to (5), are reimbursed by
160.17 medical assistance ~~must~~ when they meet the following standards:

160.18 ~~(1) case management service component must meet the standards in Minnesota~~
160.19 ~~Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;~~

160.20 (1) psychotherapy provided by a mental health professional as defined in Minnesota
160.21 Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota
160.22 Rules, part 9505.0371, subpart 5, item C;

160.23 ~~(2) psychotherapy, crisis assistance, and skills training components must meet the~~
160.24 provided according to standards for children's therapeutic services and supports in section
160.25 256B.0943; ~~and~~

160.26 ~~(3) individual family, and group psychoeducation services under supervision of,~~
160.27 defined in subdivision 1a, paragraph (q), provided by a mental health professional; or a
160.28 clinical trainee;

160.29 ~~(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental~~
160.30 health professional or a clinical trainee; and

160.31 (5) service delivery payment requirements as provided under subdivision 4.

160.32 **Subd. 1a. Definitions.** For the purposes of this section, the following terms have
160.33 the meanings given them.

160.34 (a) "Clinical care consultation" means communication from a treating clinician to
160.35 other providers working with the same client to inform, inquire, and instruct regarding

161.1 the client's symptoms, strategies for effective engagement, care and intervention needs,
161.2 and treatment expectations across service settings, including but not limited to the client's
161.3 school, social services, day care, probation, home, primary care, medication prescribers,
161.4 disabilities services, and other mental health providers and to direct and coordinate clinical
161.5 service components provided to the client and family.

161.6 (b) "Clinical supervision" means the documented time a clinical supervisor and
161.7 supervisee spend together to discuss the supervisee's work, to review individual client
161.8 cases, and for the supervisee's professional development. It includes the documented
161.9 oversight and supervision responsibility for planning, implementation, and evaluation of
161.10 services for a client's mental health treatment.

161.11 (c) "Clinical supervisor" means the mental health professional who is responsible
161.12 for clinical supervision.

161.13 (d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371,
161.14 subpart 5, item C;

161.15 (e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a,
161.16 including the development of a plan that addresses prevention and intervention strategies
161.17 to be used in a potential crisis, but does not include actual crisis intervention.

161.18 (f) "Culturally appropriate" means providing mental health services in a manner that
161.19 incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370,
161.20 subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural
161.21 strengths and resources to promote overall wellness.

161.22 (g) "Culture" means the distinct ways of living and understanding the world that
161.23 are used by a group of people and are transmitted from one generation to another or
161.24 adopted by an individual.

161.25 (h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part
161.26 9505.0370, subpart 11.

161.27 (i) "Family" means a person who is identified by the client or the client's parent or
161.28 guardian as being important to the client's mental health treatment. Family may include,
161.29 but is not limited to, parents, foster parents, children, spouse, committed partners, former
161.30 spouses, persons related by blood or adoption, persons who are a part of the client's
161.31 permanency plan, or persons who are presently residing together as a family unit.

161.32 (j) "Foster care" has the meaning given in section 260C.007, subdivision 18.

161.33 (k) "Foster family setting" means the foster home in which the license holder resides.

161.34 (l) "Individual treatment plan" has the meaning given in Minnesota Rules, part
161.35 9505.0370, subpart 15.

162.1 (m) "Mental health practitioner" has the meaning given in Minnesota Rules, part
162.2 9505.0370, subpart 17.

162.3 (n) "Mental health professional" has the meaning given in Minnesota Rules, part
162.4 9505.0370, subpart 18.

162.5 (o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370,
162.6 subpart 20.

162.7 (p) "Parent" has the meaning given in section 260C.007, subdivision 25.

162.8 (q) "Psychoeducation services" means information or demonstration provided to
162.9 an individual, family, or group to explain, educate, and support the individual, family, or
162.10 group in understanding a child's symptoms of mental illness, the impact on the child's
162.11 development, and needed components of treatment and skill development so that the
162.12 individual, family, or group can help the child to prevent relapse, prevent the acquisition
162.13 of comorbid disorders, and achieve optimal mental health and long-term resilience.

162.14 (r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370,
162.15 subpart 27.

162.16 (s) "Team consultation and treatment planning" means the coordination of treatment
162.17 plans and consultation among providers in a group concerning the treatment needs of the
162.18 child, including disseminating the child's treatment service schedule to all members of the
162.19 service team. Team members must include all mental health professionals working with
162.20 the child, a parent, the child unless the team lead or parent deem it clinically inappropriate,
162.21 and at least two of the following: an individualized education program case manager;
162.22 probation agent; children's mental health case manager; child welfare worker, including
162.23 adoption or guardianship worker; primary care provider; foster parent; and any other
162.24 member of the child's service team.

162.25 Subd. 2. **Determination of client eligibility.** ~~A client's eligibility to receive~~
162.26 ~~treatment foster care under this section shall be determined by~~ An eligible recipient is an
162.27 individual, from birth through age 20, who is currently placed in a foster home licensed
162.28 under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic
162.29 assessment; ~~and an evaluation of level of care needed, and development of an individual~~
162.30 ~~treatment plan,~~ as defined in paragraphs (a) ~~to (e)~~ and (b).

162.31 (a) The diagnostic assessment must:

162.32 (1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be
162.33 conducted by a psychiatrist, licensed psychologist, or licensed independent clinical social
162.34 worker that is mental health professional or a clinical trainee;

162.35 (2) determine whether or not a child meets the criteria for mental illness, as defined
162.36 in Minnesota Rules, part 9505.0370, subpart 20;

163.1 (3) document that intensive treatment services are medically necessary within a
163.2 foster family setting to ameliorate identified symptoms and functional impairments;
163.3 (4) be performed within 180 days prior to before the start of service; and
163.4 ~~(2) include current diagnoses on all five axes of the client's current mental health~~
163.5 ~~status;~~
163.6 ~~(3) determine whether or not a child meets the criteria for severe emotional~~
163.7 ~~disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness~~
163.8 ~~in section 245.462, subdivision 20; and~~
163.9 ~~(4) be completed annually until age 18. For individuals between age 18 and 21,~~
163.10 ~~unless a client's mental health condition has changed markedly since the client's most~~
163.11 ~~recent diagnostic assessment, annual updating is necessary. For the purpose of this section,~~
163.12 ~~"updating" means a written summary, including current diagnoses on all five axes, by a~~
163.13 ~~mental health professional of the client's current mental status and service needs.~~
163.14 (5) be completed as either a standard or extended diagnostic assessment annually to
163.15 determine continued eligibility for the service.
163.16 (b) The evaluation of level of care must be conducted by the placing county with
163.17 an instrument, tribe, or case manager in conjunction with the diagnostic assessment as
163.18 described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool
163.19 approved by the commissioner of human services and not subject to the rulemaking
163.20 process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which
163.21 evaluation demonstrates that the child requires intensive intervention without 24-hour
163.22 medical monitoring. The commissioner shall update the list of approved level of care
163.23 instruments tools annually and publish on the department's Web site.
163.24 (c) The individual treatment plan must be:
163.25 ~~(1) based on the information in the client's diagnostic assessment;~~
163.26 ~~(2) developed through a child-centered, family driven planning process that identifies~~
163.27 ~~service needs and individualized, planned, and culturally appropriate interventions that~~
163.28 ~~contain specific measurable treatment goals and objectives for the client and treatment~~
163.29 ~~strategies for the client's family and foster family;~~
163.30 ~~(3) reviewed at least once every 90 days and revised; and~~
163.31 ~~(4) signed by the client or, if appropriate, by the client's parent or other person~~
163.32 ~~authorized by statute to consent to mental health services for the client.~~
163.33 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for
163.34 intensive children's mental health services in a foster family setting must be certified
163.35 by the state and have a service provision contract with a county board or a reservation

164.1 tribal council and must be able to demonstrate the ability to provide all of the services
164.2 required in this section.

164.3 (b) For purposes of this section, a provider agency must ~~have an individual~~
164.4 ~~placement agreement for each recipient and must be a licensed child placing agency, under~~
164.5 ~~Minnesota Rules, parts 9543.0010 to 9543.0150, and either be:~~

164.6 (1) a ~~county~~ county-operated entity certified by the state;

164.7 (2) an Indian Health Services facility operated by a tribe or tribal organization under
164.8 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
164.9 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

164.10 (3) a noncounty entity ~~under contract with a county board.~~

164.11 (c) Certified providers that do not meet the service delivery standards required in
164.12 this section shall be subject to a decertification process.

164.13 (d) For the purposes of this section, all services delivered to a client must be
164.14 provided by a mental health professional or a clinical trainee.

164.15 **Subd. 4. ~~Eligible provider responsibilities~~ Service delivery payment**

164.16 **requirements.** (a) To be an eligible provider for payment under this section, a provider
164.17 must develop and practice written policies and procedures for ~~treatment foster care services~~
164.18 ~~intensive treatment in foster care~~, consistent with subdivision 1, paragraph (b), ~~clauses (1),~~
164.19 ~~(2), and (3)~~ and comply with the following requirements in paragraphs (b) to (n).

164.20 (b) ~~In delivering services under this section, a treatment foster care provider must~~
164.21 ~~ensure that staff caseload size reasonably enables the provider to play an active role in~~
164.22 ~~service planning, monitoring, delivering, and reviewing for discharge planning to meet~~
164.23 ~~the needs of the client, the client's foster family, and the birth family, as specified in each~~
164.24 ~~client's individual treatment plan.~~

164.25 (b) A qualified clinical supervisor, as defined in and performing in compliance with
164.26 Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and
164.27 provision of services described in this section.

164.28 (c) Each client receiving treatment services must receive an extended diagnostic
164.29 assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within
164.30 30 days of enrollment in this service unless the client has a previous extended diagnostic
164.31 assessment that the client, parent, and mental health professional agree still accurately
164.32 describes the client's current mental health functioning.

164.33 (d) Each previous and current mental health, school, and physical health treatment
164.34 provider must be contacted to request documentation of treatment and assessments that
164.35 the eligible client has received. This information must be reviewed and incorporated into
164.36 the diagnostic assessment and team consultation and treatment planning review process.

165.1 (e) Each client receiving treatment must be assessed for a trauma history, and
165.2 the client's treatment plan must document how the results of the assessment will be
165.3 incorporated into treatment.

165.4 (f) Each client receiving treatment services must have an individual treatment plan
165.5 that is reviewed, evaluated, and signed every 90 days using the team consultation and
165.6 treatment planning process, as defined in subdivision 1a, paragraph (s).

165.7 (g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided
165.8 in accordance with the client's individual treatment plan.

165.9 (h) Each client must have a crisis assistance plan within ten days of initiating
165.10 services and must have access to clinical phone support 24 hours per day, seven days per
165.11 week, during the course of treatment. The crisis plan must demonstrate coordination with
165.12 the local or regional mobile crisis intervention team.

165.13 (i) Services must be delivered and documented at least three days per week, equaling
165.14 at least six hours of treatment per week, unless reduced units of service are specified on
165.15 the treatment plan as part of transition or on a discharge plan to another service or level of
165.16 care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

165.17 (j) Location of service delivery must be in the client's home, day care setting,
165.18 school, or other community-based setting that is specified on the client's individualized
165.19 treatment plan.

165.20 (k) Treatment must be developmentally and culturally appropriate for the client.

165.21 (l) Services must be delivered in continual collaboration and consultation with the
165.22 client's medical providers and, in particular, with prescribers of psychotropic medications,
165.23 including those prescribed on an off-label basis. Members of the service team must be
165.24 aware of the medication regimen and potential side effects.

165.25 (m) Parents, siblings, foster parents, and members of the child's permanency plan
165.26 must be involved in treatment and service delivery unless otherwise noted in the treatment
165.27 plan.

165.28 (n) Transition planning for the child must be conducted starting with the first
165.29 treatment plan and must be addressed throughout treatment to support the child's
165.30 permanency plan and postdischarge mental health service needs.

165.31 **Subd. 5. Service authorization.** The commissioner will administer authorizations
165.32 for services under this section in compliance with section 256B.0625, subdivision 25.

165.33 **Subd. 6. Excluded services.** (a) Services in clauses (1) to ~~(4)~~ (7) are not covered
165.34 under this section and are not eligible for medical assistance payment as components of
165.35 intensive treatment in foster care services, but may be billed separately:

166.1 ~~(1) treatment foster care services provided in violation of medical assistance policy~~
166.2 ~~in Minnesota Rules, part 9505.0220;~~

166.3 ~~(2) service components of children's therapeutic services and supports~~
166.4 ~~simultaneously provided by more than one treatment foster care provider;~~

166.5 ~~(3) home and community-based waiver services; and~~

166.6 ~~(4) treatment foster care services provided to a child without a level of care~~
166.7 ~~determination according to section 245.4885, subdivision 1.~~

166.8 (1) inpatient psychiatric hospital treatment;

166.9 (2) mental health targeted case management;

166.10 (3) partial hospitalization;

166.11 (4) medication management;

166.12 (5) children's mental health day treatment services;

166.13 (6) crisis response services under section 256B.0944; and

166.14 (7) transportation.

166.15 (b) Children receiving intensive treatment in foster care services are not eligible for
166.16 medical assistance reimbursement for the following services while receiving intensive
166.17 treatment in foster care:

166.18 ~~(1) mental health case management services under section 256B.0625, subdivision~~
166.19 ~~20; and~~

166.20 ~~(2) (1) psychotherapy and skill skills training components of children's therapeutic~~
166.21 ~~services and supports under section 256B.0625, subdivision 35b.2;~~

166.22 (2) mental health behavioral aide services as defined in section 256B.0943,
166.23 subdivision 1, paragraph (m);

166.24 (3) home and community-based waiver services;

166.25 (4) mental health residential treatment; and

166.26 (5) room and board costs as defined in section 256I.03, subdivision 6.

166.27 **Subd. 7. Medical assistance payment and rate setting.** The commissioner shall
166.28 establish a single daily per-client encounter rate for intensive treatment in foster care
166.29 services. The rate must be constructed to cover only eligible services delivered to an
166.30 eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

166.31 Sec. 27. Minnesota Statutes 2012, section 256B.49, is amended by adding a
166.32 subdivision to read:

166.33 **Subd. 24. Waiver allocations for transition populations.** (a) The commissioner
166.34 shall make available additional waiver allocations and additional necessary resources

167.1 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
167.2 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

167.3 (1) are otherwise eligible for the brain injury, community alternatives for disabled
167.4 individuals, or community alternative care waivers under this section;

167.5 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
167.6 the Minnesota Security Hospital;

167.7 (3) whose discharge would be significantly delayed without the available waiver
167.8 allocation; and

167.9 (4) who have met treatment objectives and no longer meet hospital level of care.

167.10 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
167.11 requirements of the federal approved waiver plan.

167.12 (c) Any corporate foster care home developed under this subdivision must be
167.13 considered an exception under section 245A.03, subdivision 7, paragraph (a).

167.14 **EFFECTIVE DATE.** This section is effective July 1, 2013.

167.15 Sec. 28. Minnesota Statutes 2012, section 256B.761, is amended to read:

167.16 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

167.17 (a) Effective for services rendered on or after July 1, 2001, payment for medication
167.18 management provided to psychiatric patients, outpatient mental health services, day
167.19 treatment services, home-based mental health services, and family community support
167.20 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
167.21 50th percentile of 1999 charges.

167.22 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
167.23 services provided by an entity that operates: (1) a Medicare-certified comprehensive
167.24 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
167.25 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
167.26 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
167.27 when those services are provided within the comprehensive outpatient rehabilitation
167.28 facility and provided to residents of nursing facilities owned by the entity.

167.29 (c) The commissioner shall establish three levels of payment for mental health
167.30 diagnostic assessment, based on three levels of complexity. The aggregate payment under
167.31 the tiered rates must not exceed the projected aggregate payments for mental health
167.32 diagnostic assessment under the previous single rate. The new rate structure is effective
167.33 January 1, 2011, or upon federal approval, whichever is later.

168.1 (d) In addition to rate increases otherwise provided, the commissioner may
168.2 restructure coverage policy and rates to improve access to adult rehabilitative mental
168.3 health services under section 256B.0623 and related mental health support services under
168.4 section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and
168.5 2016, the projected state share of increased costs due to this paragraph is transferred
168.6 from adult mental health grants under sections 245.4661 and 256E.12. The transfer for
168.7 fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments
168.8 made to managed care plans and county-based purchasing plans under sections 256B.69,
168.9 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

168.10 **Sec. 29. CHILD AND ADOLESCENT BEHAVIORAL HEALTH SERVICES.**

168.11 The commissioner of human services shall, in consultation with children's mental
168.12 health community providers, hospitals providing care to children, children's mental health
168.13 advocates, and other interested parties, develop recommendations and legislation, if
168.14 necessary, for the state-operated child and adolescent behavioral health services facility
168.15 to ensure that:

168.16 (1) the facility and the services provided meet the needs of children with serious
168.17 emotional disturbances, autism spectrum disorders, reactive attachment disorder, PTSD,
168.18 serious emotional disturbance co-occurring with a developmental disability, borderline
168.19 personality disorder, schizophrenia, fetal alcohol spectrum disorders, brain injuries,
168.20 violent tendencies, and complex medical issues;

168.21 (2) qualified personnel and staff can be recruited who have specific expertise and
168.22 training to treat the children in the facility; and

168.23 (3) the treatment provided at the facility is high-quality, effective treatment.

168.24 **Sec. 30. PILOT PROVIDER INPUT SURVEY OF PEDIATRIC SERVICES AND**
168.25 **CHILDREN'S MENTAL HEALTH SERVICES.**

168.26 (a) To assess the efficiency and other operational issues in the management of the
168.27 health care delivery system, the commissioner of human services shall initiate a provider
168.28 survey. The pilot survey shall consist of an electronic survey of providers of pediatric
168.29 home health care services and children's mental health services to identify and measure
168.30 issues that arise in dealing with the management of medical assistance. To the maximum
168.31 degree possible, existing technology shall be used and interns sought to analyze the results.

168.32 (b) The survey questions must focus on seven key business functions provided
168.33 by medical assistance contractors: provider inquiries; provider outreach and education;
168.34 claims processing; appeals; provider enrollment; medical review; and provider audit and

169.1 reimbursement. The commissioner must consider the results of the survey in evaluating
169.2 and renewing managed care and fee-for-service management contracts.

169.3 (c) The commissioner shall report by January 15, 2014, the results of the survey to
169.4 the chairs of the health and human services policy and finance committees and shall
169.5 make recommendations on the value of implementing an annual survey with a rotating
169.6 list of provider groups as a component of the continuous quality improvement system for
169.7 medical assistance.

169.8 Sec. 31. **MENTALLY ILL AND DANGEROUS COMMITMENTS**
169.9 **STAKEHOLDERS GROUP.**

169.10 (a) The commissioner of human services, in consultation with the state court
169.11 administrator, shall convene a stakeholder group to develop recommendations for the
169.12 legislature that address issues raised in the February 2013 Office of the Legislative
169.13 Auditor report on State-Operated Services for persons committed to the commissioner as
169.14 mentally ill and dangerous under Minnesota Statutes, section 253B.18. Stakeholders must
169.15 include representatives from the Department of Human Services, county human services,
169.16 county attorneys, commitment defense attorneys, the ombudsman for mental health and
169.17 developmental disabilities, the federal protection and advocacy system, and consumers
169.18 and advocates for persons with mental illnesses.

169.19 (b) The stakeholder group shall provide recommendations in the following areas:

169.20 (1) the role of the special review board, including the scope of authority of the
169.21 special review board and the authority of the commissioner to accept or reject special
169.22 review board recommendations;

169.23 (2) review of special review board decisions by the district court;

169.24 (3) annual district court review of commitment, scope of court authority, and
169.25 appropriate review criteria;

169.26 (4) options, including annual court hearing and review, as alternatives to
169.27 indeterminate commitment under Minnesota Statutes, section 253B.18; and

169.28 (5) extension of the right to petition the court under Minnesota Statutes,
169.29 section 253B.17, to those committed under Minnesota Statutes, section 253B.18.

169.30 The commissioner of human services and the state court administrator shall provide
169.31 relevant data for the group's consideration in developing these recommendations,
169.32 including numbers of proceedings in each category and costs associated with court and
169.33 administrative proceedings under Minnesota Statutes, section 253B.18.

169.34 (c) By January 15, 2014, the commissioner of human services shall submit the
169.35 recommendations of the stakeholder group to the chairs and ranking minority members

170.1 of the committees of the legislature with jurisdiction over civil commitment and human
170.2 services issues.

170.3 Sec. 32. **STATE ASSISTANCE TO COUNTIES; TRANSITIONS FOR HIGH**
170.4 **NEEDS POPULATIONS.**

170.5 (a) Effective immediately, the commissioner of human services shall work with
170.6 counties that request assistance to assure timely discharge from Anoka Metro Regional
170.7 Treatment Center and the Minnesota Security Hospital for individuals who are ready
170.8 for discharge but for whom the county may not have provider resources or appropriate
170.9 placement available. Special consideration must be given to uninsured individuals who are
170.10 not eligible for medical assistance and who may need continued treatment, and individuals
170.11 with complex needs and other factors that hinder county efforts to place the individual in a
170.12 safe, affordable setting.

170.13 (b) The commissioner shall assure that, given Olmstead court directives and the
170.14 role family and friends play in treatment progress, metropolitan area residents are asked
170.15 whether they wished to be placed in an Intensive Residential Treatment Service program
170.16 at Willmar or Cambridge or to be placed in a location more accessible to family, friends,
170.17 and health providers.

170.18 **ARTICLE 5**

170.19 **DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY**

170.20 Section 1. Minnesota Statutes 2012, section 13.461, is amended by adding a
170.21 subdivision to read:

170.22 Subd. 7b. **Child care provider and recipient fraud investigations.** Data related
170.23 to child care fraud and recipient fraud investigations are governed by section 245E.01,
170.24 subdivision 15.

170.25 Sec. 2. Minnesota Statutes 2012, section 243.166, subdivision 7, is amended to read:

170.26 Subd. 7. **Use of data.** (a) Except as otherwise provided in subdivision 7a or sections
170.27 244.052 and 299C.093, the data provided under this section is private data on individuals
170.28 under section 13.02, subdivision 12.

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

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

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

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

171.5 Sec. 3. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision
171.6 to read:

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

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

171.25 Sec. 4. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:

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

171.29 (1) information related to names of substantiated perpetrators of maltreatment of
171.30 vulnerable adults that has been received by the commissioner as required under section
171.31 626.557, subdivision 9c, paragraph (j);

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

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

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

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

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

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

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

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

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

172.23 **Sec. 5. [245E.01] CHILD CARE PROVIDER AND RECIPIENT FRAUD**
172.24 **INVESTIGATIONS WITHIN THE CHILD CARE ASSISTANCE PROGRAM.**

172.25 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this
172.26 subdivision have the meanings given them.

172.27 (b) "Applicant" has the meaning given in section 119B.011, subdivision 2.

172.28 (c) "Child care assistance program" means any of the assistance programs under
172.29 chapter 119B.

172.30 (d) "Commissioner" means the commissioner of human services.

172.31 (e) "Controlling individual" has the meaning given in section 245A.02, subdivision
172.32 5a.

172.33 (f) "County" means a local county child care assistance program staff or
172.34 subcontracted staff, or a county investigator acting on behalf of the commissioner.

172.35 (g) "Department" means the Department of Human Services.

173.1 (h) "Financial misconduct" or "misconduct" means an entity's or individual's acts or
173.2 omissions that result in fraud and abuse or error against the Department of Human Services.

173.3 (i) "Identify" means to furnish the full name, current or last known address, phone
173.4 number, and e-mail address of the individual or business entity.

173.5 (j) "License holder" has the meaning given in section 245A.02, subdivision 9.

173.6 (k) "Mail" means the use of any mail service with proof of delivery and receipt.

173.7 (l) "Provider" means either a provider as defined in section 119B.011, subdivision
173.8 19, or a legal unlicensed provider as defined in section 119B.011, subdivision 16.

173.9 (m) "Recipient" means a family receiving assistance as defined under section
173.10 119B.011, subdivision 13.

173.11 (n) "Terminate" means revocation of participation in the child care assistance
173.12 program.

173.13 **Subd. 2. Investigating provider or recipient financial misconduct.** The
173.14 department shall investigate alleged or suspected financial misconduct by providers and
173.15 errors related to payments issued by the child care assistance program under this chapter.
173.16 Recipients, employees, and staff may be investigated when the evidence shows that their
173.17 conduct is related to the financial misconduct of a provider, license holder, or controlling
173.18 individual.

173.19 **Subd. 3. Scope of investigations.** (a) The department may contact any person,
173.20 agency, organization, or other entity that is necessary to an investigation.

173.21 (b) The department may examine or interview any individual, document, or piece of
173.22 evidence that may lead to information that is relevant to child care assistance program
173.23 benefits, payments, and child care provider authorizations. This includes, but is not
173.24 limited to:

173.25 (1) child care assistance program payments;

173.26 (2) services provided by the program or related to child care assistance program
173.27 recipients;

173.28 (3) services provided to a provider;

173.29 (4) provider financial records of any type;

173.30 (5) daily attendance records of the children receiving services from the provider;

173.31 (6) billings; and

173.32 (7) verification of the credentials of a license holder, controlling individual,
173.33 employee, staff person, contractor, subcontractor, and entities under contract with the
173.34 provider to provide services or maintain service and the provider's financial records
173.35 related to those services.

174.1 Subd. 4. **Determination of investigation.** After completing its investigation, the
174.2 department shall issue one of the following determinations:

174.3 (1) no violation of child care assistance requirements occurred;

174.4 (2) there is insufficient evidence to show that a violation of child care assistance
174.5 requirements occurred;

174.6 (3) a preponderance of evidence shows a violation of child care assistance program
174.7 law, rule, or policy; or

174.8 (4) there exists a credible allegation of fraud.

174.9 Subd. 5. **Actions or administrative sanctions.** (a) After completing the
174.10 determination under subdivision 4, the department may take one or more of the actions
174.11 or sanctions specified in this subdivision.

174.12 (b) The department may take the following actions:

174.13 (1) refer the investigation to law enforcement or a county attorney for possible
174.14 criminal prosecution;

174.15 (2) refer relevant information to the department's licensing division, the child care
174.16 assistance program, the Department of Education, the federal child and adult care food
174.17 program, or appropriate child or adult protection agency;

174.18 (3) enter into a settlement agreement with a provider, license holder, controlling
174.19 individual, or recipient; or

174.20 (4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction
174.21 for possible civil action under the Minnesota False Claims Act, chapter 15C.

174.22 (c) In addition to section 256.98, the department may impose sanctions by:

174.23 (1) pursuing administrative disqualification through hearings or waivers;

174.24 (2) establishing and seeking monetary recovery or recoupment; or

174.25 (3) issuing an order of corrective action that states the practices that are violations of
174.26 child care assistance program policies, laws, or regulations, and that they must be corrected.

174.27 Subd. 6. **Duty to provide access.** (a) A provider, license holder, controlling
174.28 individual, employee, staff person, or recipient has an affirmative duty to provide access
174.29 upon request to information specified under subdivision 8 or the program facility.

174.30 (b) Failure to provide access may result in denial or termination of authorizations for
174.31 or payments to a recipient, provider, license holder, or controlling individual in the child
174.32 care assistance program.

174.33 (c) When a provider fails to provide access, a 15-day notice of denial or termination
174.34 must be issued to the provider, which prohibits the provider from participating in the child
174.35 care assistance program. Notice must be sent to recipients whose children are under the
174.36 provider's care pursuant to Minnesota Rules, part 3400.0185.

175.1 (d) If the provider continues to fail to provide access at the expiration of the 15-day
175.2 notice period, child care assistance program payments to the provider must be denied
175.3 beginning the 16th day following notice of the initial failure or refusal to provide access.
175.4 The department may rescind the denial based upon good cause if the provider submits in
175.5 writing a good cause basis for having failed or refused to provide access. The writing must
175.6 be postmarked no later than the 15th day following the provider's notice of initial failure
175.7 to provide access. Additionally, the provider, license holder, or controlling individual
175.8 must immediately provide complete, ongoing access to the department. Repeated failures
175.9 to provide access must, after the initial failure or for any subsequent failure, result in
175.10 termination from participation in the child care assistance program.

175.11 (e) The department, at its own expense, may photocopy or otherwise duplicate
175.12 records referenced in subdivision 8. Photocopying must be done on the provider's
175.13 premises on the day of the request or other mutually agreeable time, unless removal of
175.14 records is specifically permitted by the provider. If requested, a provider, license holder,
175.15 or controlling individual, or a designee, must assist the investigator in duplicating any
175.16 record, including a hard copy or electronically stored data, on the day of the request.

175.17 (f) A provider, license holder, controlling individual, employee, or staff person must
175.18 grant the department access during the department's normal business hours, and any hours
175.19 that the program is operated, to examine the provider's program or the records listed in
175.20 subdivision 8. A provider shall make records available at the provider's place of business
175.21 on the day for which access is requested, unless the provider and the department both agree
175.22 otherwise. The department's normal business hours are 8:00 a.m. to 5:00 p.m., Monday
175.23 through Friday, excluding state holidays as defined in section 645.44, subdivision 5.

175.24 Subd. 7. **Honest and truthful statements.** It shall be unlawful for a provider,
175.25 license holder, controlling individual, or recipient to:

175.26 (1) falsify, conceal, or cover up by any trick, scheme, or device a material fact;

175.27 (2) make any materially false, fictitious, or fraudulent statement or representation; or

175.28 (3) make or use any false writing or document knowing the same to contain any

175.29 materially false, fictitious, or fraudulent statement or entry related to any child care

175.30 assistance program services that the provider, license holder, or controlling individual

175.31 supplies or in relation to any child care assistance payments received by a provider, license

175.32 holder, or controlling individual or to any fraud investigator or law enforcement officer

175.33 conducting a financial misconduct investigation.

175.34 Subd. 8. **Record retention.** (a) The following records must be maintained,

175.35 controlled, and made immediately accessible to license holders, providers, and controlling

175.36 individuals. The records must be organized and labeled to correspond to categories that

176.1 make them easy to identify so that they can be made available immediately upon request
176.2 to an investigator acting on behalf of the commissioner at the provider's place of business:
176.3 (1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting
176.4 records;
176.5 (2) daily attendance records required by and that comply with section 119B.125,
176.6 subdivision 6;
176.7 (3) billing transmittal forms requesting payments from the child care assistance
176.8 program and billing adjustments related to child care assistance program payments;
176.9 (4) records identifying all persons, corporations, partnerships, and entities with an
176.10 ownership or controlling interest in the provider's child care business;
176.11 (5) employee records identifying those persons currently employed by the provider's
176.12 child care business or who have been employed by the business at any time within the
176.13 previous five years. The records must include each employee's name, hourly and annual
176.14 salary, qualifications, position description, job title, and dates of employment. In addition,
176.15 employee records that must be made available include the employee's time sheets, current
176.16 home address of the employee or last known address of any former employee, and
176.17 documentation of background studies required under chapter 119B or 245C;
176.18 (6) records related to transportation of children in care, including but not limited to:
176.19 (i) the dates and times that transportation is provided to children for transportation to
176.20 and from the provider's business location for any purpose. For transportation related to
176.21 field trips or locations away from the provider's business location, the names and addresses
176.22 of those field trips and locations must also be provided;
176.23 (ii) the name, business address, phone number, and Web site address, if any, of the
176.24 transportation service utilized; and
176.25 (iii) all billing or transportation records related to the transportation.
176.26 (b) A provider, license holder, or controlling individual must retain all records in
176.27 paragraph (a) for at least six years after the last date of service. Microfilm or electronically
176.28 stored records satisfy the record keeping requirements of this subdivision.
176.29 (c) A provider, license holder, or controlling individual who withdraws or is
176.30 terminated from the child care assistance program must retain the records required under
176.31 this subdivision and make them available to the department on demand.
176.32 (d) If the ownership of a provider changes, the transferor, unless otherwise provided
176.33 by law or by written agreement with the transferee, is responsible for maintaining,
176.34 preserving, and upon request from the department, making available the records related to
176.35 the provider that were generated before the date of the transfer. Any written agreement
176.36 affecting this provision must be held in the possession of the transferor and transferee.

177.1 The written agreement must be provided to the department or county immediately upon
177.2 request, and the written agreement must be retained by the transferor and transferee for six
177.3 years after the agreement is fully executed.

177.4 (e) In the event of an appealed case, the provider must retain all records required in
177.5 this subdivision for the duration of the appeal or six years, whichever is longer.

177.6 (f) A provider's use of electronic record keeping or electronic signatures is governed
177.7 by chapter 325L.

177.8 Subd. 9. **Factors regarding imposition of administrative sanctions.** (a) The
177.9 department shall consider the following factors in determining the administrative sanctions
177.10 to be imposed:

177.11 (1) nature and extent of financial misconduct;

177.12 (2) history of financial misconduct;

177.13 (3) actions taken or recommended by other state agencies, other divisions of the
177.14 department, and court and administrative decisions;

177.15 (4) prior imposition of sanctions;

177.16 (5) size and type of provider;

177.17 (6) information obtained through an investigation from any source;

177.18 (7) convictions or pending criminal charges; and

177.19 (8) any other information relevant to the acts or omissions related to the financial
177.20 misconduct.

177.21 (b) Any single factor under paragraph (a) may be determinative of the department's
177.22 decision of whether and what sanctions are imposed.

177.23 Subd. 10. **Written notice of department sanction.** (a) The department shall give
177.24 notice in writing to a person of an administrative sanction that is to be imposed. The notice
177.25 shall be sent by mail as defined in subdivision 1, paragraph (k).

177.26 (b) The notice shall state:

177.27 (1) the factual basis for the department's determination;

177.28 (2) the sanction the department intends to take;

177.29 (3) the dollar amount of the monetary recovery or recoupment, if any;

177.30 (4) how the dollar amount was computed;

177.31 (5) the right to dispute the department's determination and to provide evidence;

177.32 (6) the right to appeal the department's proposed sanction; and

177.33 (7) the option to meet informally with department staff, and to bring additional
177.34 documentation or information, to resolve the issues.

177.35 (c) In cases of determinations resulting in denial or termination of payments, in
177.36 addition to the requirements of paragraph (b), the notice must state:

178.1 (1) the length of the denial or termination;
178.2 (2) the requirements and procedures for reinstatement; and
178.3 (3) the provider's right to submit documents and written arguments against the
178.4 denial or termination of payments for review by the department before the effective date
178.5 of denial or termination.

178.6 (d) The submission of documents and written argument for review by the department
178.7 under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the
178.8 deadline for filing an appeal.

178.9 (e) Unless timely appealed, the effective date of the proposed sanction shall be 30
178.10 days after the license holder's, provider's, controlling individual's, or recipient's receipt of
178.11 the notice. If a timely appeal is made, the proposed sanction shall be delayed pending
178.12 the final outcome of the appeal. Implementation of a proposed sanction following the
178.13 resolution of a timely appeal may be postponed if, in the opinion of the department, the
178.14 delay of sanction is necessary to protect the health or safety of children in care. The
178.15 department may consider the economic hardship of a person in implementing the proposed
178.16 sanction, but economic hardship shall not be a determinative factor in implementing the
178.17 proposed sanction.

178.18 (f) Requests for an informal meeting to attempt to resolve issues and requests
178.19 for appeals must be sent or delivered to the department's Office of Inspector General,
178.20 Financial Fraud and Abuse Division.

178.21 Subd. 11. **Appeal of department sanction under this section.** (a) If the department
178.22 does not pursue a criminal action against a provider, license holder, controlling individual,
178.23 or recipient for financial misconduct, but the department imposes an administrative
178.24 sanction under subdivision 5, paragraph (c), any individual or entity against whom the
178.25 sanction was imposed may appeal the department's administrative sanction under this
178.26 section pursuant to section 119B.16 or 256.045 with the additional requirements in clauses
178.27 (1) to (4). An appeal must specify:

178.28 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
178.29 amount involved for each disputed item, if appropriate;

178.30 (2) the computation that is believed to be correct, if appropriate;

178.31 (3) the authority in the statute or rule relied upon for each disputed item; and

178.32 (4) the name, address, and phone number of the person at the provider's place of
178.33 business with whom contact may be made regarding the appeal.

178.34 (b) An appeal is considered timely only if postmarked or received by the department's
178.35 Appeals Division within 30 days after receiving a notice of department sanction.

179.1 (c) Before the appeal hearing, the department may deny or terminate authorizations
179.2 or payment to the entity or individual if the department determines that the action is
179.3 necessary to protect the public welfare or the interests of the child care assistance program.

179.4 Subd. 12. **Consolidated hearings with licensing sanction.** If a financial
179.5 misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing
179.6 sanction exists for which there is an appeal hearing right and the sanction is timely
179.7 appealed, and the overpayment recovery action and licensing sanction involve the same
179.8 set of facts, the overpayment recovery action and licensing sanction must be consolidated
179.9 in the contested case hearing related to the licensing sanction.

179.10 Subd. 13. **Grounds for and methods of monetary recovery.** (a) The department
179.11 may obtain monetary recovery from a provider who has been improperly paid by the
179.12 child care assistance program, regardless of whether the error was intentional or county
179.13 error. The department does not need to establish a pattern as a precondition of monetary
179.14 recovery of erroneous or false billing claims, duplicate billing claims, or billing claims
179.15 based on false statements or financial misconduct.

179.16 (b) The department shall obtain monetary recovery from providers by the following
179.17 means:

179.18 (1) permitting voluntary repayment of money, either in lump-sum payment or
179.19 installment payments;

179.20 (2) using any legal collection process;

179.21 (3) deducting or withholding program payments; or

179.22 (4) utilizing the means set forth in chapter 16D.

179.23 Subd. 14. **Reporting of suspected fraudulent activity.** (a) A person who, in
179.24 good faith, makes a report of or testifies in any action or proceeding in which financial
179.25 misconduct is alleged, and who is not involved in, has not participated in, or has not aided
179.26 and abetted, conspired, or colluded in the financial misconduct, shall have immunity from
179.27 any liability, civil or criminal, that results by reason of the person's report or testimony.
179.28 For the purpose of any proceeding, the good faith of any person reporting or testifying
179.29 under this provision shall be presumed.

179.30 (b) If a person that is or has been involved in, participated in, aided and abetted,
179.31 conspired, or colluded in the financial misconduct reports the financial misconduct,
179.32 the department may consider that person's report and assistance in investigating the
179.33 misconduct as a mitigating factor in the department's pursuit of civil, criminal, or
179.34 administrative remedies.

180.1 Subd. 15. **Data privacy.** Data of any kind obtained or created in relation to a provider
180.2 or recipient investigation under this section is defined, classified, and protected the same as
180.3 all other data under section 13.46, and this data has the same classification as licensing data.

180.4 Subd. 16. **Monetary recovery; random sample extrapolation.** The department is
180.5 authorized to calculate the amount of monetary recovery from a provider, license holder, or
180.6 controlling individual based upon extrapolation from a statistical random sample of claims
180.7 submitted by the provider, license holder, or controlling individual and paid by the child
180.8 care assistance program. The department's random sample extrapolation shall constitute a
180.9 rebuttable presumption of the accuracy of the calculation of monetary recovery. If the
180.10 presumption is not rebutted by the provider, license holder, or controlling individual in the
180.11 appeal process, the department shall use the extrapolation as the monetary recovery figure.
180.12 The department may use sampling and extrapolation to calculate the amount of monetary
180.13 recovery if the claims to be reviewed represent services to 50 or more children in care.

180.14 Subd. 17. **Effect of department's monetary penalty determination.** Unless a
180.15 timely and proper appeal is received by the department, the department's administrative
180.16 determination or sanction shall be considered a final department determination.

180.17 Subd. 18. **Office of Inspector General recoveries.** Overpayment recoveries
180.18 resulting from child care provider fraud investigations initiated by the department's Office
180.19 of Inspector General's fraud investigations staff are excluded from the county recovery
180.20 provision in section 119B.11, subdivision 3.

180.21 Sec. 6. Minnesota Statutes 2012, section 256B.04, subdivision 21, is amended to read:

180.22 **Subd. 21. **Provider enrollment.**** (a) If the commissioner or the Centers for
180.23 Medicare and Medicaid Services determines that a provider is designated "high-risk," the
180.24 commissioner may withhold payment from providers within that category upon initial
180.25 enrollment for a 90-day period. The withholding for each provider must begin on the date
180.26 of the first submission of a claim.

180.27 (b) An enrolled provider that is also licensed by the commissioner under chapter
180.28 245A must designate an individual as the entity's compliance officer. The compliance
180.29 officer must:

180.30 (1) develop policies and procedures to assure adherence to medical assistance laws
180.31 and regulations and to prevent inappropriate claims submissions;

180.32 (2) train the employees of the provider entity, and any agents or subcontractors of
180.33 the provider entity including billers, on the policies and procedures under clause (1);

180.34 (3) respond to allegations of improper conduct related to the provision or billing of
180.35 medical assistance services, and implement action to remediate any resulting problems;

181.1 (4) use evaluation techniques to monitor compliance with medical assistance laws
181.2 and regulations;

181.3 (5) promptly report to the commissioner any identified violations of medical
181.4 assistance laws or regulations; and

181.5 (6) within 60 days of discovery by the provider of a medical assistance
181.6 reimbursement overpayment, report the overpayment to the commissioner and make
181.7 arrangements with the commissioner for the commissioner's recovery of the overpayment.

181.8 The commissioner may require, as a condition of enrollment in medical assistance, that a
181.9 provider within a particular industry sector or category establish a compliance program that
181.10 contains the core elements established by the Centers for Medicare and Medicaid Services.

181.11 (c) The commissioner may revoke the enrollment of an ordering or rendering
181.12 provider for a period of not more than one year, if the provider fails to maintain and, upon
181.13 request from the commissioner, provide access to documentation relating to written orders
181.14 or requests for payment for durable medical equipment, certifications for home health
181.15 services, or referrals for other items or services written or ordered by such provider, when
181.16 the commissioner has identified a pattern of a lack of documentation. A pattern means a
181.17 failure to maintain documentation or provide access to documentation on more than one
181.18 occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a
181.19 provider under the provisions of section 256B.064.

181.20 (d) The commissioner shall terminate or deny the enrollment of any individual or
181.21 entity if the individual or entity has been terminated from participation in Medicare or
181.22 under the Medicaid program or Children's Health Insurance Program of any other state.

181.23 (e) As a condition of enrollment in medical assistance, the commissioner shall
181.24 require that a provider designated "moderate" or "high-risk" by the Centers for Medicare
181.25 and Medicaid Services or the ~~Minnesota Department of Human Services~~ commissioner
181.26 permit the Centers for Medicare and Medicaid Services, its agents, or its designated
181.27 contractors and the state agency, its agents, or its designated contractors to conduct
181.28 unannounced on-site inspections of any provider location. The commissioner shall publish
181.29 in the Minnesota Health Care Program Provider Manual a list of provider types designated
181.30 "limited," "moderate," or "high-risk," based on the criteria and standards used to designate
181.31 Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and
181.32 criteria are not subject to the requirements of chapter 14. The commissioner's designations
181.33 are not subject to administrative appeal.

181.34 (f) As a condition of enrollment in medical assistance, the commissioner shall
181.35 require that a high-risk provider, or a person with a direct or indirect ownership interest in
181.36 the provider of five percent or higher, consent to criminal background checks, including

182.1 fingerprinting, when required to do so under state law or by a determination by the
182.2 commissioner or the Centers for Medicare and Medicaid Services that a provider is
182.3 designated high-risk for fraud, waste, or abuse.

182.4 (g)(1) Upon initial enrollment, reenrollment, and revalidation, all durable medical
182.5 equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers operating in
182.6 Minnesota and receiving Medicaid funds, must purchase a surety bond that is annually
182.7 renewed and designates the Minnesota Department of Human Services as the obligee, and
182.8 must be submitted in a form approved by the commissioner.

182.9 (2) At the time of initial enrollment or reenrollment, the provider agency must
182.10 purchase a performance bond of \$50,000. If a revalidating provider's Medicaid revenue
182.11 in the previous calendar year is up to and including \$300,000, the provider agency must
182.12 purchase a performance bond of \$50,000. If a revalidating provider's Medicaid revenue
182.13 in the previous calendar year is over \$300,000, the provider agency must purchase a
182.14 performance bond of \$100,000. The performance bond must allow for recovery of costs
182.15 and fees in pursuing a claim on the bond.

182.16 (h) The Department of Human Services may require a provider to purchase a
182.17 performance surety bond as a condition of initial enrollment, reenrollment, reinstatement,
182.18 or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the
182.19 department determines there is significant evidence of or potential for fraud and abuse by
182.20 the provider, or (3) the provider or category of providers is designated high-risk pursuant
182.21 to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The
182.22 performance bond must be in an amount of \$100,000 or ten percent of the provider's
182.23 payments from Medicaid during the immediately preceding 12 months, whichever is
182.24 greater. The performance bond must name the Department of Human Services as an
182.25 obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

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

182.27 Sec. 7. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision
182.28 to read:

182.29 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
182.30 required nonrefundable application fees to pay for provider screening activities in
182.31 accordance with Code of Federal Regulations, title 42, section 455, subpart E. The
182.32 enrollment application must be made under the procedures specified by the commissioner,
182.33 in the form specified by the commissioner, and accompanied by an application fee
182.34 described in paragraph (b), or a request for a hardship exception as described in the
182.35 specified procedures. Application fees must be deposited in the provider screening account

183.1 in the special revenue fund. Amounts in the provider screening account are appropriated
183.2 to the commissioner for costs associated with the provider screening activities required
183.3 in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner
183.4 shall conduct screening activities as required by Code of Federal Regulations, title 42,
183.5 section 455, subpart E, and as otherwise provided by law, to include database checks,
183.6 unannounced pre- and postenrollment site visits, fingerprinting, and criminal background
183.7 studies. The commissioner must revalidate all providers under this subdivision at least
183.8 once every five years.

183.9 (b) The application fee under this subdivision is \$532 for the calendar year 2013.
183.10 For calendar year 2014 and subsequent years, the fee:

183.11 (1) is adjusted by the percentage change to the consumer price index for all urban
183.12 consumers, United States city average, for the 12-month period ending with June of the
183.13 previous year. The resulting fee must be announced in the Federal Register;

183.14 (2) is effective from January 1 to December 31 of a calendar year;

183.15 (3) is required on the submission of an initial application, an application to establish
183.16 a new practice location, an application for re-enrollment when the provider is not enrolled
183.17 at the time of application of re-enrollment, or at revalidation when required by federal
183.18 regulation; and

183.19 (4) must be in the amount in effect for the calendar year during which the application
183.20 for enrollment, new practice location, or re-enrollment is being submitted.

183.21 (c) The application fee under this subdivision cannot be charged to:

183.22 (1) providers who are enrolled in Medicare or who provide documentation of
183.23 payment of the fee to, and enrollment with, another state, unless the commissioner is
183.24 required to rescreen the provider;

183.25 (2) providers who are enrolled but are required to submit new applications for
183.26 purposes of reenrollment;

183.27 (3) a provider who enrolls as an individual; and

183.28 (4) group practices and clinics that bill on behalf of individually enrolled providers
183.29 within the practice who have reassigned their billing privileges to the group practice
183.30 or clinic.

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

183.32 Sec. 8. Minnesota Statutes 2012, section 256B.064, subdivision 1a, is amended to read:

183.33 Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may
183.34 impose sanctions against a vendor of medical care for any of the following: (1) fraud,
183.35 theft, or abuse in connection with the provision of medical care to recipients of public

184.1 assistance; (2) a pattern of presentment of false or duplicate claims or claims for services
184.2 not medically necessary; (3) a pattern of making false statements of material facts for
184.3 the purpose of obtaining greater compensation than that to which the vendor is legally
184.4 entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state
184.5 agency access during regular business hours to examine all records necessary to disclose
184.6 the extent of services provided to program recipients and appropriateness of claims for
184.7 payment; (6) failure to repay an overpayment or a fine finally established under this
184.8 section; ~~and~~ (7) failure to correct errors in the maintenance of health service or financial
184.9 records for which a fine was imposed or after issuance of a warning by the commissioner;
184.10 and (8) any reason for which a vendor could be excluded from participation in the
184.11 Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.
184.12 The determination of services not medically necessary may be made by the commissioner
184.13 in consultation with a peer advisory task force appointed by the commissioner on the
184.14 recommendation of appropriate professional organizations. The task force expires as
184.15 provided in section 15.059, subdivision 5.

184.16 Sec. 9. Minnesota Statutes 2012, section 256B.064, subdivision 1b, is amended to read:

184.17 Subd. 1b. **Sanctions available.** The commissioner may impose the following
184.18 sanctions for the conduct described in subdivision 1a: suspension or withholding of
184.19 payments to a vendor and suspending or terminating participation in the program, or
184.20 imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under
184.21 this section, the commissioner shall consider the nature, chronicity, or severity of the
184.22 conduct and the effect of the conduct on the health and safety of persons served by the
184.23 vendor. Regardless of imposition of sanctions, the commissioner may make a referral
184.24 to the appropriate state licensing board.

184.25 Sec. 10. Minnesota Statutes 2012, section 256B.064, subdivision 2, is amended to read:

184.26 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner
184.27 shall determine any monetary amounts to be recovered and sanctions to be imposed upon
184.28 a vendor of medical care under this section. Except as provided in paragraphs (b) and
184.29 (d), neither a monetary recovery nor a sanction will be imposed by the commissioner
184.30 without prior notice and an opportunity for a hearing, according to chapter 14, on the
184.31 commissioner's proposed action, provided that the commissioner may suspend or reduce
184.32 payment to a vendor of medical care, except a nursing home or convalescent care facility,
184.33 after notice and prior to the hearing if in the commissioner's opinion that action is
184.34 necessary to protect the public welfare and the interests of the program.

185.1 (b) Except when the commissioner finds good cause not to suspend payments under
185.2 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall
185.3 withhold or reduce payments to a vendor of medical care without providing advance
185.4 notice of such withholding or reduction if either of the following occurs:

185.5 (1) the vendor is convicted of a crime involving the conduct described in subdivision
185.6 1a; or

185.7 (2) the commissioner determines there is a credible allegation of fraud for which an
185.8 investigation is pending under the program. A credible allegation of fraud is an allegation
185.9 which has been verified by the state, from any source, including but not limited to:

185.10 (i) fraud hotline complaints;

185.11 (ii) claims data mining; and

185.12 (iii) patterns identified through provider audits, civil false claims cases, and law
185.13 enforcement investigations.

185.14 Allegations are considered to be credible when they have an indicia of reliability
185.15 and the state agency has reviewed all allegations, facts, and evidence carefully and acts
185.16 judiciously on a case-by-case basis.

185.17 (c) The commissioner must send notice of the withholding or reduction of payments
185.18 under paragraph (b) within five days of taking such action unless requested in writing by a
185.19 law enforcement agency to temporarily withhold the notice. The notice must:

185.20 (1) state that payments are being withheld according to paragraph (b);

185.21 (2) set forth the general allegations as to the nature of the withholding action, but
185.22 need not disclose any specific information concerning an ongoing investigation;

185.23 (3) except in the case of a conviction for conduct described in subdivision 1a, state
185.24 that the withholding is for a temporary period and cite the circumstances under which
185.25 withholding will be terminated;

185.26 (4) identify the types of claims to which the withholding applies; and

185.27 (5) inform the vendor of the right to submit written evidence for consideration by
185.28 the commissioner.

185.29 The withholding or reduction of payments will not continue after the commissioner
185.30 determines there is insufficient evidence of fraud by the vendor, or after legal proceedings
185.31 relating to the alleged fraud are completed, unless the commissioner has sent notice of
185.32 intention to impose monetary recovery or sanctions under paragraph (a).

185.33 (d) The commissioner shall suspend or terminate a vendor's participation in the
185.34 program without providing advance notice and an opportunity for a hearing when the
185.35 suspension or termination is required because of the vendor's exclusion from participation

186.1 in Medicare. Within five days of taking such action, the commissioner must send notice of
186.2 the suspension or termination. The notice must:

186.3 (1) state that suspension or termination is the result of the vendor's exclusion from
186.4 Medicare;

186.5 (2) identify the effective date of the suspension or termination; and

186.6 (3) inform the vendor of the need to be reinstated to Medicare before reapplying
186.7 for participation in the program.

186.8 (e) Upon receipt of a notice under paragraph (a) that a monetary recovery or
186.9 sanction is to be imposed, a vendor may request a contested case, as defined in section
186.10 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The
186.11 appeal request must be received by the commissioner no later than 30 days after the date
186.12 the notification of monetary recovery or sanction was mailed to the vendor. The appeal
186.13 request must specify:

186.14 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
186.15 amount involved for each disputed item;

186.16 (2) the computation that the vendor believes is correct;

186.17 (3) the authority in statute or rule upon which the vendor relies for each disputed item;

186.18 (4) the name and address of the person or entity with whom contacts may be made
186.19 regarding the appeal; and

186.20 (5) other information required by the commissioner.

186.21 (f) The commissioner may order a vendor to forfeit a fine for failure to fully document
186.22 services according to standards in this chapter and Minnesota Rules, chapter 9505. The
186.23 commissioner may assess fines if specific required components of documentation are
186.24 missing. The fine for incomplete documentation shall equal 20 percent of the amount paid
186.25 on the claims for reimbursement submitted by the vendor, or up to \$5,000, whichever is less.

186.26 (g) The vendor shall pay the fine assessed on or before the payment date specified. If
186.27 the vendor fails to pay the fine, the commissioner may withhold or reduce payments and
186.28 recover the amount of the fine. A timely appeal shall stay payment of the fine until the
186.29 commissioner issues a final order.

186.30 Sec. 11. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to
186.31 read:

186.32 Subd. 21. **Requirements for initial provider enrollment of personal care**
186.33 **assistance provider agencies.** (a) All personal care assistance provider agencies must
186.34 provide, at the time of enrollment, reenrollment, and revalidation as a personal care

187.1 assistance provider agency in a format determined by the commissioner, information and
187.2 documentation that includes, but is not limited to, the following:

187.3 (1) the personal care assistance provider agency's current contact information
187.4 including address, telephone number, and e-mail address;

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

187.7 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's
187.8 Medicaid revenue in the previous calendar year is up to and including \$300,000,
187.9 the provider agency must purchase a performance bond of \$50,000. If the Medicaid
187.10 revenue in the previous year is over \$300,000, the provider agency must purchase a
187.11 performance bond of \$100,000. The performance bond must be in a form approved by the
187.12 commissioner, must be renewed annually, and must allow for recovery of costs and fees
187.13 in pursuing a claim on the bond;

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

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

187.16 (5) proof of liability insurance;

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

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

187.25 (8) copies of all other forms the personal care assistance provider agency uses in
187.26 the course of daily business including, but not limited to:

187.27 (i) a copy of the personal care assistance provider agency's time sheet if the time
187.28 sheet varies from the standard time sheet for personal care assistance services approved
187.29 by the commissioner, and a letter requesting approval of the personal care assistance
187.30 provider agency's nonstandard time sheet;

187.31 (ii) the personal care assistance provider agency's template for the personal care
187.32 assistance care plan; and

187.33 (iii) the personal care assistance provider agency's template for the written
187.34 agreement in subdivision 20 for recipients using the personal care assistance choice
187.35 option, if applicable;

188.1 (9) a list of all training and classes that the personal care assistance provider agency
188.2 requires of its staff providing personal care assistance services;

188.3 (10) documentation that the personal care assistance provider agency and staff have
188.4 successfully completed all the training required by this section;

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

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

188.8 (13) documentation that the agency will use the following percentages of revenue
188.9 generated from the medical assistance rate paid for personal care assistance services
188.10 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
188.11 personal care assistance choice option and 72.5 percent of revenue from other personal
188.12 care assistance providers. The revenue generated by the qualified professional and the
188.13 reasonable costs associated with the qualified professional shall not be used in making
188.14 this calculation; and

188.15 (14) effective May 15, 2010, documentation that the agency does not burden
188.16 recipients' free exercise of their right to choose service providers by requiring personal
188.17 care assistants to sign an agreement not to work with any particular personal care
188.18 assistance recipient or for another personal care assistance provider agency after leaving
188.19 the agency and that the agency is not taking action on any such agreements or requirements
188.20 regardless of the date signed.

188.21 (b) Personal care assistance provider agencies shall provide the information specified
188.22 in paragraph (a) to the commissioner at the time the personal care assistance provider
188.23 agency enrolls as a vendor or upon request from the commissioner. The commissioner
188.24 shall collect the information specified in paragraph (a) from all personal care assistance
188.25 providers beginning July 1, 2009.

188.26 (c) All personal care assistance provider agencies shall require all employees in
188.27 management and supervisory positions and owners of the agency who are active in the
188.28 day-to-day management and operations of the agency to complete mandatory training
188.29 as determined by the commissioner before enrollment of the agency as a provider.
188.30 Employees in management and supervisory positions and owners who are active in
188.31 the day-to-day operations of an agency who have completed the required training as
188.32 an employee with a personal care assistance provider agency do not need to repeat
188.33 the required training if they are hired by another agency, if they have completed the
188.34 training within the past three years. By September 1, 2010, the required training must
188.35 be available with meaningful access according to title VI of the Civil Rights Act and
188.36 federal regulations adopted under that law or any guidance from the United States Health

189.1 and Human Services Department. The required training must be available online or by
189.2 electronic remote connection. The required training must provide for competency testing.
189.3 Personal care assistance provider agency billing staff shall complete training about
189.4 personal care assistance program financial management. This training is effective July 1,
189.5 2009. Any personal care assistance provider agency enrolled before that date shall, if it
189.6 has not already, complete the provider training within 18 months of July 1, 2009. Any new
189.7 owners or employees in management and supervisory positions involved in the day-to-day
189.8 operations are required to complete mandatory training as a requisite of working for the
189.9 agency. Personal care assistance provider agencies certified for participation in Medicare
189.10 as home health agencies are exempt from the training required in this subdivision. When
189.11 available, Medicare-certified home health agency owners, supervisors, or managers must
189.12 successfully complete the competency test.

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

189.14 Sec. 12. Minnesota Statutes 2012, section 299C.093, is amended to read:

189.15 **299C.093 DATABASE OF REGISTERED PREDATORY OFFENDERS.**

189.16 The superintendent of the Bureau of Criminal Apprehension shall maintain a
189.17 computerized data system relating to individuals required to register as predatory offenders
189.18 under section 243.166. To the degree feasible, the system must include the data required
189.19 to be provided under section 243.166, subdivisions 4 and 4a, and indicate the time period
189.20 that the person is required to register. The superintendent shall maintain this data in a
189.21 manner that ensures that it is readily available to law enforcement agencies. This data is
189.22 private data on individuals under section 13.02, subdivision 12, but may be used for law
189.23 enforcement and corrections purposes. The commissioner of human services has access
189.24 to the data for state-operated services, as defined in section 246.014, are also authorized
189.25 to have access to the data for the purposes described in section 246.13, subdivision 2,
189.26 paragraph (b), and for purposes of conducting background studies under chapter 245C.

189.27 Sec. 13. Minnesota Statutes 2012, section 402A.10, is amended to read:

189.28 **402A.10 DEFINITIONS.**

189.29 Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined
189.30 in this section have the meanings given.

189.31 Subd. 1a. **Balanced set of program measures.** A "balanced set of program
189.32 measures" is a set of measures that, together, adequately quantify achievement toward a
189.33 particular program's outcome. As directed by section 402A.16, the Human Services

190.1 Performance Council must recommend to the commissioner when a particular program
190.2 has a balanced set of program measures.

190.3 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human
190.4 services.

190.5 Subd. 3. **Council.** "Council" means the State-County Results, Accountability, and
190.6 Service Delivery Redesign Council established in section 402A.20.

190.7 Subd. 4. **Essential human services or essential services.** "Essential human
190.8 services" or "essential services" means assistance and services to recipients or potential
190.9 recipients of public welfare and other services delivered by counties or tribes that are
190.10 mandated in federal and state law that are to be available in all counties of the state.

190.11 Subd. 4a. **Essential human services program.** An "essential human services
190.12 program" for the purposes of remedies under section 402A.18 means the following
190.13 programs:

190.14 (1) child welfare, including protection, truancy, minor parent, guardianship, and
190.15 adoption;

190.16 (2) children's mental health;

190.17 (3) children's disability services;

190.18 (4) public assistance eligibility, including measures related to processing timelines
190.19 across information services programs;

190.20 (5) MFIP;

190.21 (6) child support;

190.22 (7) chemical dependency;

190.23 (8) adult disability;

190.24 (9) adult mental health;

190.25 (10) adult services such as long-term care; and

190.26 (11) adult protection.

190.27 Subd. 4b. **Measure.** A "measure" means a quantitative indicator of a performance
190.28 outcome.

190.29 Subd. 4c. **Performance improvement plan.** A "performance improvement plan"
190.30 means a plan developed by a county or service delivery authority that describes steps the
190.31 county or service delivery authority must take to improve performance on a specific
190.32 measure or set of measures. The performance improvement plan must be negotiated
190.33 with and approved by the commissioner. The performance improvement plan must
190.34 require a specific numerical improvement in the measure or measures on which the plan
190.35 is based and may include specific programmatic best practices or specific performance
190.36 management practices that the county must implement.

191.1 Subd. 4d. **Performance management system for human services.** A "performance
191.2 management system for human services" means a process by which performance data for
191.3 essential human services is collected from counties or service delivery authorities and used
191.4 to inform a variety of stakeholders and to improve performance over time.

191.5 Subd. 5. **Service delivery authority.** "Service delivery authority" means a single
191.6 county, or consortium of counties operating by execution of a joint powers agreement
191.7 under section 471.59 or other contractual agreement, that has voluntarily chosen by
191.8 resolution of the county board of commissioners to participate in the redesign under this
191.9 chapter or has been assigned by the commissioner pursuant to section 402A.18. A service
191.10 delivery authority includes an Indian tribe or group of tribes that have voluntarily chosen
191.11 by resolution of tribal government to participate in redesign under this chapter.

191.12 Subd. 6. **Steering committee.** "Steering committee" means the Steering Committee
191.13 on Performance and Outcome Reforms.

191.14 Sec. 14. **[402A.12] ESTABLISHMENT OF A PERFORMANCE MANAGEMENT**
191.15 **SYSTEM FOR HUMAN SERVICES.**

191.16 By January 1, 2014, the commissioner shall implement a performance management
191.17 system for essential human services as described in sections 402A.15 to 402A.18 that
191.18 includes initial performance measures and standards consistent with the recommendations
191.19 of the Steering Committee on Performance and Outcome Reforms in the December 2012
191.20 report to the legislature.

191.21 Sec. 15. **[402A.16] HUMAN SERVICES PERFORMANCE COUNCIL.**

191.22 Subdivision 1. **Establishment.** By October 1, 2013, the commissioner shall convene
191.23 a Human Services Performance Council to advise the commissioner on the implementation
191.24 and operation of the performance management system for human services.

191.25 Subd. 2. **Duties.** The Human Services Performance Council shall:

191.26 (1) hold meetings at least quarterly that are in compliance with Minnesota's Open
191.27 Meeting Law under chapter 13D;

191.28 (2) annually review the annual performance data submitted by counties or service
191.29 delivery authorities;

191.30 (3) review and advise the commissioner on department procedures related to the
191.31 implementation of the performance management system and system process requirements
191.32 and on barriers to process improvement in human services delivery;

191.33 (4) advise the commissioner on the training and technical assistance needs of county
191.34 or service delivery authority and department personnel;

192.1 (5) review instances in which a county or service delivery authority has not made
192.2 adequate progress on a performance improvement plan and make recommendations to
192.3 the commissioner under section 402A.18;

192.4 (6) consider appeals from counties or service delivery authorities that are in the
192.5 remedies process and make recommendations to the commissioner on resolving the issue;

192.6 (7) convene working groups to update and develop outcomes, measures, and
192.7 performance standards for the performance management system and, on an annual basis,
192.8 present these recommendations to the commissioner, including recommendations on when
192.9 a particular essential human service program has a balanced set of program measures
192.10 in place;

192.11 (8) make recommendations on human services administrative rules or statutes that
192.12 could be repealed in order to improve service delivery;

192.13 (9) provide information to stakeholders on the council's role and regularly collect
192.14 stakeholder input on performance management system performance; and

192.15 (10) submit an annual report to the legislature and the commissioner, which
192.16 includes a comprehensive report on the performance of individual counties or service
192.17 delivery authorities as it relates to system measures; a list of counties or service delivery
192.18 authorities that have been required to create performance improvement plans and the areas
192.19 identified for improvement as part of the remedies process; a summary of performance
192.20 improvement training and technical assistance activities offered to the county personnel
192.21 by the department; recommendations on administrative rules or state statutes that could be
192.22 repealed in order to improve service delivery; recommendations for system improvements,
192.23 including updates to system outcomes, measures, and standards; and a response from
192.24 the commissioner.

192.25 Subd. 3. **Membership.** (a) Human Services Performance Council membership shall
192.26 be equally balanced among the following five stakeholder groups: the Association of
192.27 Minnesota Counties, the Minnesota Association of County Social Service Administrators,
192.28 the Department of Human Services, tribes and communities of color, and service providers
192.29 and advocates for persons receiving human services. The Association of Minnesota
192.30 Counties and the Minnesota Association of County Social Service Administrators shall
192.31 appoint their own respective representatives. The commissioner of human services shall
192.32 appoint representatives of the Department of Human Services, tribes and communities of
192.33 color, and social services providers and advocates. Minimum council membership shall
192.34 be 15 members, with at least three representatives from each stakeholder group, and
192.35 maximum council membership shall be 20 members, with four representatives from
192.36 each stakeholder group.

193.1 (b) Notwithstanding section 15.059, Human Services Performance Council members
193.2 shall be appointed for a minimum of two years, but may serve longer terms at the
193.3 discretion of their appointing authority.

193.4 (c) Notwithstanding section 15.059, members of the council shall receive no
193.5 compensation for their services.

193.6 (d) A commissioner's representative and a county representative from either the
193.7 Association of Minnesota Counties or the Minnesota Association of County Social Service
193.8 Administrators shall serve as Human Services Performance Council cochairs.

193.9 Subd. 4. Commissioner duties. The commissioner shall:

193.10 (1) implement and maintain the performance management system for human services;

193.11 (2) establish and regularly update the system's outcomes, measures, and standards,
193.12 including the minimum performance standard for each performance measure;

193.13 (3) determine when a particular program has a balanced set of measures;

193.14 (4) receive reports from counties or service delivery authorities at least annually on
193.15 their performance against system measures, provide counties with data needed to assess
193.16 performance and monitor progress, and provide timely feedback to counties or service
193.17 delivery authorities on their performance;

193.18 (5) implement and monitor the remedies process in section 402A.18;

193.19 (6) report to the Human Services Performance Council on county or service delivery
193.20 authority performance on a semiannual basis;

193.21 (7) provide general training and technical assistance to counties or service delivery
193.22 authorities on topics related to performance measurement and performance improvement;

193.23 (8) provide targeted training and technical assistance to counties or service delivery
193.24 authorities that supports their performance improvement plans; and

193.25 (9) provide staff support for the Human Services Performance Council.

193.26 Subd. 5. County or service delivery authority duties. The counties or service
193.27 delivery authorities shall:

193.28 (1) report performance data to meet performance management system requirements;

193.29 and

193.30 (2) provide training to personnel on basic principles of performance measurement
193.31 and improvement and participate in training provided by the department.

193.32 Sec. 16. Minnesota Statutes 2012, section 402A.18, is amended to read:

193.33 **402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET**
193.34 **PERFORMANCE OUTCOMES.**

194.1 Subdivision 1. **Underperforming county; specific service.** If the commissioner
194.2 determines that a county or service delivery authority is deficient in achieving minimum
194.3 performance ~~outcomes~~ standards for a specific essential service human services program,
194.4 the commissioner may impose the following remedies and adjust state and federal
194.5 program allocations accordingly:

194.6 (1) voluntary incorporation of the administration and operation of the specific
194.7 essential service human services program with an existing service delivery authority or
194.8 another county. A service delivery authority or county incorporating an underperforming
194.9 county shall not be financially liable for the costs associated with remedying performance
194.10 outcome deficiencies;

194.11 (2) mandatory incorporation of the administration and operation of the specific
194.12 essential service human services program with an existing service delivery authority or
194.13 another county. A service delivery authority or county incorporating an underperforming
194.14 county shall not be financially liable for the costs associated with remedying performance
194.15 outcome deficiencies; or

194.16 (3) transfer of authority for program administration and operation of the specific
194.17 essential service human services program to the commissioner.

194.18 Subd. 2. **Underperforming county; more than one-half of services.** If the
194.19 commissioner determines that a county or service delivery authority is deficient in
194.20 achieving minimum performance ~~outcomes~~ standards for more than one-half of the defined
194.21 essential human services programs, the commissioner may impose the following remedies:

194.22 (1) voluntary incorporation of the administration and operation of essential human
194.23 services programs with an existing service delivery authority or another county. A
194.24 service delivery authority or county incorporating an underperforming county shall
194.25 not be financially liable for the costs associated with remedying performance outcome
194.26 deficiencies;

194.27 (2) mandatory incorporation of the administration and operation of essential human
194.28 services programs with an existing service delivery authority or another county. A
194.29 service delivery authority or county incorporating an underperforming county shall
194.30 not be financially liable for the costs associated with remedying performance outcome
194.31 deficiencies; or

194.32 (3) transfer of authority for ~~program~~ administration and operation of essential human
194.33 services programs to the commissioner.

194.34 Subd. 2a. **Financial responsibility of underperforming county.** A county subject
194.35 to remedies under subdivision 1 or 2 shall provide to the entity assuming administration

195.1 of the ~~essential service or~~ essential human services program or programs the amount of
195.2 nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

195.3 Subd. 3. **Conditions prior to imposing remedies.** ~~Before the commissioner may~~
195.4 ~~impose the remedies authorized under this section, the following conditions must be met:~~

195.5 (1) ~~the county or service delivery authority determined by the commissioner~~
195.6 ~~to be deficient in achieving minimum performance outcomes has the opportunity, in~~
195.7 ~~coordination with the council, to develop a program outcome improvement plan. The~~
195.8 ~~program outcome improvement plan must be developed no later than six months from the~~
195.9 ~~date of the deficiency determination; and~~

195.10 (2) ~~the council has conducted an assessment of the program outcome improvement~~
195.11 ~~plan to determine if the county or service delivery authority has made satisfactory progress~~
195.12 ~~toward performance outcomes and has made a recommendation about remedies to the~~
195.13 ~~commissioner. The assessment and recommendation must be made to the commissioner~~
195.14 ~~within 12 months from the date of the deficiency determination. (a) The commissioner~~
195.15 ~~shall notify a county or service delivery authority that it must submit a performance~~
195.16 ~~improvement plan if:~~

195.17 (1) the county or service delivery authority does not meet the minimum performance
195.18 standard for a measure; or

195.19 (2) the county or service delivery authority does not meet the minimum performance
195.20 standard for one or more racial or ethnic subgroup for which there is a statistically valid
195.21 population size for three or more measures, even if the county or service delivery authority
195.22 met the standard for the overall population.

195.23 The commissioner must approve the performance improvement plan. The county or
195.24 service delivery authority may negotiate the terms of the performance improvement plan
195.25 with the commissioner.

195.26 (b) When the department determines that a county or service delivery authority does
195.27 not meet the minimum performance standard for a given measure, the commissioner
195.28 must advise the county or service delivery authority that fiscal penalties may result if the
195.29 performance does not improve. The department must offer technical assistance to the
195.30 county or service delivery authority. Within 30 days of the initial advisement from the
195.31 department, the county or service delivery authority may claim and the department may
195.32 approve an extenuating circumstance that relieves the county or service delivery authority
195.33 of any further remedy. If a county or service delivery authority has a small number of
195.34 participants in an essential human services program such that reliable measurement is
195.35 not possible, the commissioner may approve extenuating circumstances or may average
195.36 performance over three years.

196.1 (c) If there are no extenuating circumstances, the county or service delivery authority
196.2 must submit a performance improvement plan to the commissioner within 60 days of the
196.3 initial advisement from the department. The term of the performance improvement plan
196.4 must be two years, starting with the date the plan is approved by the commissioner. This
196.5 plan must include a target level for improvement for each measure that did not meet
196.6 the minimum performance standard. The commissioner must approve the performance
196.7 improvement plan within 60 days of submittal.

196.8 (d) The department must monitor the performance improvement plan for two
196.9 years. After two years, if the county or service delivery authority meets the minimum
196.10 performance standard, there is no further remedy. If the county or service delivery
196.11 authority fails to meet the minimum performance standard, but meets the improvement
196.12 target in the performance improvement plan, the county or service delivery authority shall
196.13 modify the performance improvement plan for further improvement and the department
196.14 shall continue to monitor the plan.

196.15 (e) If, after two years of monitoring, the county or service delivery authority fails to
196.16 meet both the minimum performance standard and the improvement target identified in
196.17 the performance improvement plan, the next step of the remedies process shall be invoked
196.18 by the commissioner. This phase of the remedies process may include:

196.19 (1) fiscal penalties for the county or service delivery authority that do not exceed
196.20 one percent of the county's human services expenditures and that are negotiated in the
196.21 performance improvement plan, based on what is needed to improve outcomes. Counties
196.22 or service delivery authorities must reinvest the amount of the fiscal penalty into the
196.23 essential human services program that was underperforming. A county or service delivery
196.24 authority shall not be required to pay more than three fiscal penalties in a year; and

196.25 (2) the department's provision of technical assistance to the county or service
196.26 delivery authority that is targeted to address the specific performance issues.
196.27 The commissioner shall continue monitoring the performance improvement plan for a
196.28 third year.

196.29 (f) If, after the third year of monitoring, the county or service delivery authority
196.30 meets the minimum performance standard, there is no further remedy. If the county or
196.31 service delivery authority fails to meet the minimum performance standard, but meets the
196.32 improvement target for the performance improvement plan, the county or service delivery
196.33 authority shall modify the performance improvement plan for further improvement and
196.34 the department shall continue to monitor the plan.

196.35 (g) If, after the third year of monitoring, the county or service delivery authority fails
196.36 to meet the minimum performance standard and the improvement target identified in the

197.1 performance improvement plan, the Human Services Performance Council shall review
197.2 the situation and recommend a course of action to the commissioner.

197.3 (h) If the commissioner has determined that a program has a balanced set of program
197.4 measures and a county or service delivery authority is subject to fiscal penalties for more
197.5 than one-half of the measures for that program, the commissioner may apply further
197.6 remedies as described in subdivisions 1 and 2.

197.7 Sec. 17. **INSTRUCTIONS TO THE COMMISSIONER.**

197.8 In collaboration with labor organizations, the commissioner of human services shall
197.9 develop clear and consistent standards for state-operated services programs to:

197.10 (1) address direct service staffing shortages;

197.11 (2) identify and help resolve workplace safety issues; and

197.12 (3) elevate the use and visibility of performance measures and objectives related to
197.13 overtime use.

197.14 **ARTICLE 6**

197.15 **HEALTH CARE**

197.16 Section 1. Minnesota Statutes 2012, section 245.03, subdivision 1, is amended to read:

197.17 Subdivision 1. **Establishment.** There is created a Department of Human Services.

197.18 A commissioner of human services shall be appointed by the governor under the
197.19 provisions of section 15.06. The commissioner shall be selected on the basis of ability and
197.20 experience in welfare and without regard to political affiliations. The commissioner ~~shall~~
197.21 may appoint a up to two deputy commissioner commissioners.

197.22 Sec. 2. Minnesota Statutes 2012, section 256.9657, subdivision 3, is amended to read:

197.23 Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a)
197.24 Effective October 1, 1992, each health maintenance organization with a certificate of
197.25 authority issued by the commissioner of health under chapter 62D and each community
197.26 integrated service network licensed by the commissioner under chapter 62N shall pay to
197.27 the commissioner of human services a surcharge equal to six-tenths of one percent of the
197.28 total premium revenues of the health maintenance organization or community integrated
197.29 service network as reported to the commissioner of health according to the schedule in
197.30 subdivision 4.

197.31 (b) For purposes of this subdivision, total premium revenue means:

197.32 (1) premium revenue recognized on a prepaid basis from individuals and groups
197.33 for provision of a specified range of health services over a defined period of time which

198.1 is normally one month, excluding premiums paid to a health maintenance organization
198.2 or community integrated service network from the Federal Employees Health Benefit
198.3 Program;

198.4 (2) premiums from Medicare wraparound subscribers for health benefits which
198.5 supplement Medicare coverage;

198.6 (3) Medicare revenue, as a result of an arrangement between a health maintenance
198.7 organization or a community integrated service network and the Centers for Medicare
198.8 and Medicaid Services of the federal Department of Health and Human Services, for
198.9 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited
198.10 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social
198.11 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and
198.12 1395w-24, respectively, as they may be amended from time to time; and

198.13 (4) medical assistance revenue, as a result of an arrangement between a health
198.14 maintenance organization or community integrated service network and a Medicaid state
198.15 agency, for services to a medical assistance beneficiary.

198.16 If advance payments are made under clause (1) or (2) to the health maintenance
198.17 organization or community integrated service network for more than one reporting period,
198.18 the portion of the payment that has not yet been earned must be treated as a liability.

198.19 (c) When a health maintenance organization or community integrated service
198.20 network merges or consolidates with or is acquired by another health maintenance
198.21 organization or community integrated service network, the surviving corporation or the
198.22 new corporation shall be responsible for the annual surcharge originally imposed on
198.23 each of the entities or corporations subject to the merger, consolidation, or acquisition,
198.24 regardless of whether one of the entities or corporations does not retain a certificate of
198.25 authority under chapter 62D or a license under chapter 62N.

198.26 (d) Effective ~~July 1~~ June 15 of each year, the surviving corporation's or the new
198.27 corporation's surcharge shall be based on the revenues earned in the ~~second~~ previous
198.28 calendar year by all of the entities or corporations subject to the merger, consolidation,
198.29 or acquisition regardless of whether one of the entities or corporations does not retain a
198.30 certificate of authority under chapter 62D or a license under chapter 62N until the total
198.31 premium revenues of the surviving corporation include the total premium revenues of all
198.32 the merged entities as reported to the commissioner of health.

198.33 (e) When a health maintenance organization or community integrated service
198.34 network, which is subject to liability for the surcharge under this chapter, transfers,
198.35 assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability

199.1 for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer
199.2 of the health maintenance organization or community integrated service network.

199.3 (f) In the event a health maintenance organization or community integrated service
199.4 network converts its licensure to a different type of entity subject to liability for the
199.5 surcharge under this chapter, but survives in the same or substantially similar form, the
199.6 surviving entity remains liable for the surcharge regardless of whether one of the entities
199.7 or corporations does not retain a certificate of authority under chapter 62D or a license
199.8 under chapter 62N.

199.9 (g) The surcharge assessed to a health maintenance organization or community
199.10 integrated service network ends when the entity ceases providing services for premiums
199.11 and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

199.12 Sec. 3. Minnesota Statutes 2012, section 256.9657, subdivision 4, is amended to read:

199.13 Subd. 4. **Payments into the account.** (a) Payments to the commissioner under
199.14 ~~subdivisions~~ subdivision 1 to 3 must be paid in monthly installments due on the 15th of
199.15 the month beginning October 15, 1992. The monthly payment must be equal to the annual
199.16 surcharge divided by 12. ~~Payments to the commissioner under subdivisions 2 and 3 for~~
199.17 ~~fiscal year 1993 must be based on calendar year 1990 revenues. Effective July 1 of each~~
199.18 ~~year, beginning in 1993, payments under subdivisions 2 and 3 must be based on revenues~~
199.19 ~~earned in the second previous calendar year.~~

199.20 (b) Effective October 15, 2014, payment to the commissioner under subdivision 2
199.21 must be paid in nine monthly installments due on the 15th of the month beginning October
199.22 15, 2014, through June 15 of the following year. The monthly payment must be equal
199.23 to the annual surcharge divided by nine.

199.24 (b) (c) Effective October 1, 1995 2014, and each October 1 thereafter, the payments
199.25 in ~~subdivisions~~ subdivision 2 and 3 must be based on revenues earned in the previous
199.26 calendar year.

199.27 (e) (d) If the commissioner of health does not provide by August 15 of any year data
199.28 needed to update the base year for the hospital and or April 15 of any year data needed to
199.29 update the base year for the health maintenance organization surcharges, the commissioner
199.30 of human services may estimate base year revenue and use that estimate for the purposes
199.31 of this section until actual data is provided by the commissioner of health.

199.32 (d) (e) Payments to the commissioner under subdivision 3a must be paid in monthly
199.33 installments due on the 15th of the month beginning July 15, 2003. The monthly payment
199.34 must be equal to the annual surcharge divided by 12.

200.1 (f) Payments due in July through September 2014 under subdivision 3 for revenue
200.2 earned in calendar year 2012 shall be paid in a lump sum on June 15, 2014. On June
200.3 15, 2014, each health maintenance organization and community-integrated service
200.4 network shall pay all payments under subdivision 3 in a lump sum for revenue earned in
200.5 calendar year 2013. Effective June 15, 2015, and each June 15 thereafter, the payments in
200.6 subdivision 3 shall be based on revenues earned in the previous calendar year and paid
200.7 in a lump sum on June 15 of each year.

200.8 Sec. 4. Minnesota Statutes 2012, section 256.969, subdivision 29, is amended to read:

200.9 Subd. 29. **Reimbursement for the fee increase for the early hearing detection**
200.10 **and intervention program.** (a) For admissions occurring on or after July 1, 2010,
200.11 payment rates shall be adjusted to include the increase to the fee that is effective on July 1,
200.12 2010, for the early hearing detection and intervention program recipients under section
200.13 144.125, subdivision 1, that is paid by the hospital for public program recipients. This
200.14 payment increase shall be in effect until the increase is fully recognized in the base year
200.15 cost under subdivision 2b. This payment shall be included in payments to contracted
200.16 managed care organizations.

200.17 (b) For admissions occurring on or after July 1, 2013, payment rates shall be adjusted
200.18 to include the increase to the fee that is effective July 1, 2013, for the early hearing
200.19 detection and intervention program under section 144.125, subdivision 1, paragraph (d),
200.20 that is paid by the hospital for medical assistance and MinnesotaCare program enrollees.
200.21 This payment increase shall be in effect until the increase is fully recognized in the
200.22 base-year cost under subdivision 2b. This payment shall be included in payments to
200.23 managed care plans and county-based purchasing plans.

200.24 Sec. 5. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision
200.25 to read:

200.26 Subd. 22. **Medical assistance costs for certain inmates.** The commissioner shall
200.27 execute an interagency agreement with the commissioner of corrections to recover the
200.28 state cost attributable to medical assistance eligibility for inmates of public institutions
200.29 admitted to a medical institution on an inpatient basis. The annual amount to be transferred
200.30 from the Department of Corrections under the agreement must include all eligible state
200.31 medical assistance costs, including administrative costs incurred by the Department of
200.32 Human Services, attributable to inmates under state and county jurisdiction admitted to
200.33 medical institutions on an inpatient basis that are related to the implementation of section
200.34 256B.055, subdivision 14, paragraph (c).

201.1 Sec. 6. Minnesota Statutes 2012, section 256B.055, subdivision 14, is amended to read:

201.2 Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an
201.3 inmate of a correctional facility who is conditionally released as authorized under section
201.4 241.26, 244.065, or 631.425, if the individual does not require the security of a public
201.5 detention facility and is housed in a halfway house or community correction center, or
201.6 under house arrest and monitored by electronic surveillance in a residence approved
201.7 by the commissioner of corrections, and if the individual meets the other eligibility
201.8 requirements of this chapter.

201.9 (b) An individual who is enrolled in medical assistance, and who is charged with a
201.10 crime and incarcerated for less than 12 months shall be suspended from eligibility at the
201.11 time of incarceration until the individual is released. Upon release, medical assistance
201.12 eligibility is reinstated without reapplication using a reinstatement process and form, if the
201.13 individual is otherwise eligible.

201.14 (c) An individual, regardless of age, who is considered an inmate of a public
201.15 institution as defined in Code of Federal Regulations, title 42, section 435.1010, and
201.16 who meets the eligibility requirements in section 256B.056, is not eligible for medical
201.17 assistance, except for covered services received while an inpatient in a medical institution
201.18 as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues,
201.19 including costs, related to the inpatient treatment of an inmate are the responsibility of the
201.20 entity with jurisdiction over the inmate.

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

201.22 Sec. 7. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

202.16 (c) All qualified noncitizens who were residing in the United States before August
202.17 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
202.18 medical assistance with federal financial participation.

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

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

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

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

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

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

202.33 Beginning July 1, 2010, children and pregnant women who are noncitizens
202.34 described in paragraph (b) or who are lawfully present in the United States as defined
202.35 in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet
202.36 eligibility requirements of this chapter, are eligible for medical assistance with federal

203.1 financial participation as provided by the federal Children's Health Insurance Program
203.2 Reauthorization Act of 2009, Public Law 111-3.

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

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

203.11 (g) For purposes of this subdivision, the term "emergency medical condition" means
203.12 a medical condition that meets the requirements of United States Code, title 42, section
203.13 1396b(v).

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

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

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

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

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

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

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

203.28 (iii) services for routine prenatal care;

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

203.31 (v) elective surgery;

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

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

203.35 ~~(viii) dialysis;~~

203.36 ~~(ix) chemotherapy or therapeutic radiation services;~~

- 204.1 ~~(x)~~ (viii) rehabilitation services;
- 204.2 ~~(xi)~~ (ix) physical, occupational, or speech therapy;
- 204.3 ~~(xii)~~ (x) transportation services;
- 204.4 ~~(xiii)~~ (xi) case management;
- 204.5 ~~(xiv)~~ (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;
- 204.6 ~~(xv)~~ (xiii) dental services;
- 204.7 ~~(xvi)~~ (xiv) hospice care;
- 204.8 ~~(xvii)~~ (xv) audiology services and hearing aids;
- 204.9 ~~(xviii)~~ (xvi) podiatry services;
- 204.10 ~~(xix)~~ (xvii) chiropractic services;
- 204.11 ~~(xx)~~ (xviii) immunizations;
- 204.12 ~~(xxi)~~ (xix) vision services and eyeglasses;
- 204.13 ~~(xxii)~~ (xx) waiver services;
- 204.14 ~~(xxiii)~~ (xxi) individualized education programs; or
- 204.15 ~~(xxiv)~~ (xxii) chemical dependency treatment.

204.16 (i) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
204.17 nonimmigrants, or lawfully present in the United States as defined in Code of Federal
204.18 Regulations, title 8, section 103.12, are not covered by a group health plan or health
204.19 insurance coverage according to Code of Federal Regulations, title 42, section 457.310,
204.20 and who otherwise meet the eligibility requirements of this chapter, are eligible for
204.21 medical assistance through the period of pregnancy, including labor and delivery, and 60
204.22 days postpartum, to the extent federal funds are available under title XXI of the Social
204.23 Security Act, and the state children's health insurance program.

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

204.30 (k) Notwithstanding paragraph (h), clause (2), the following services are covered as
204.31 emergency medical conditions under paragraph (f) except where coverage is prohibited
204.32 under federal law:

- 204.33 (1) dialysis services provided in a hospital or freestanding dialysis facility; and
- 204.34 (2) surgery and the administration of chemotherapy, radiation, and related services
204.35 necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission
204.36 and requires surgery, chemotherapy, or radiation treatment.

205.1 (1) Effective July 1, 2013, recipients of emergency medical assistance under this
205.2 subdivision are eligible for coverage of the elderly waiver services provided under section
205.3 256B.0915, and coverage of rehabilitative services provided in a nursing facility. The
205.4 age limit for elderly waiver services does not apply. In order to qualify for coverage, a
205.5 recipient of emergency medical assistance is subject to the assessment and reassessment
205.6 requirements of section 256B.0911. Initial and continued enrollment under this paragraph
205.7 is subject to the limits of available funding.

205.8 **EFFECTIVE DATE.** This section is effective July 1, 2013.

205.9 Sec. 8. Minnesota Statutes 2012, section 256B.0625, subdivision 9, is amended to read:

205.10 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

205.11 (b) Medical assistance dental coverage for nonpregnant adults is limited to the
205.12 following services:

205.13 (1) comprehensive exams, limited to once every five years;

205.14 (2) periodic exams, limited to one per year;

205.15 (3) limited exams;

205.16 (4) bitewing x-rays, limited to one per year;

205.17 (5) periapical x-rays;

205.18 (6) panoramic x-rays, limited to one every five years except (1) when medically
205.19 necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma
205.20 or (2) once every two years for patients who cannot cooperate for intraoral film due to
205.21 a developmental disability or medical condition that does not allow for intraoral film
205.22 placement;

205.23 (7) prophylaxis, limited to one per year;

205.24 (8) application of fluoride varnish, limited to one per year;

205.25 (9) posterior fillings, all at the amalgam rate;

205.26 (10) anterior fillings;

205.27 (11) endodontics, limited to root canals on the anterior and premolars only;

205.28 (12) removable prostheses, each dental arch limited to one every six years;

205.29 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of
205.30 abscesses;

205.31 (14) palliative treatment and sedative fillings for relief of pain; and

205.32 (15) full-mouth debridement, limited to one every five years.

205.33 (c) In addition to the services specified in paragraph (b), medical assistance
205.34 covers the following services for adults, if provided in an outpatient hospital setting or
205.35 freestanding ambulatory surgical center as part of outpatient dental surgery:

- 206.1 (1) periodontics, limited to periodontal scaling and root planing once every two years;
- 206.2 (2) general anesthesia; and
- 206.3 (3) full-mouth survey once every five years.
- 206.4 (d) Medical assistance covers medically necessary dental services for children and
- 206.5 pregnant women. The following guidelines apply:
- 206.6 (1) posterior fillings are paid at the amalgam rate;
- 206.7 (2) application of sealants are covered once every five years per permanent molar for
- 206.8 children only;
- 206.9 (3) application of fluoride varnish is covered once every six months; and
- 206.10 (4) orthodontia is eligible for coverage for children only.
- 206.11 (e) In addition to the services specified in paragraphs (b) and (c), medical assistance
- 206.12 covers the following services for adults:
- 206.13 (1) house calls or extended care facility calls for on-site delivery of covered services;
- 206.14 (2) behavioral management when additional staff time is required to accommodate
- 206.15 behavioral challenges and sedation is not used;
- 206.16 (3) oral or IV sedation, if the covered dental service cannot be performed safely
- 206.17 without it or would otherwise require the service to be performed under general anesthesia
- 206.18 in a hospital or surgical center; and
- 206.19 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
- 206.20 no more than four times per year.

206.21 Sec. 9. Minnesota Statutes 2012, section 256B.0625, subdivision 13, is amended to read:

206.22 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs

206.23 when specifically used to enhance fertility, if prescribed by a licensed practitioner and

206.24 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance

206.25 program as a dispensing physician, or by a physician, physician assistant, or a nurse

206.26 practitioner employed by or under contract with a community health board as defined in

206.27 section 145A.02, subdivision 5, for the purposes of communicable disease control.

206.28 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,

206.29 unless authorized by the commissioner.

206.30 (c) For the purpose of this subdivision and subdivision 13d, an "active

206.31 pharmaceutical ingredient" is defined as a substance that is represented for use in a drug

206.32 and when used in the manufacturing, processing, or packaging of a drug becomes an

206.33 active ingredient of the drug product. An "excipient" is defined as an inert substance

206.34 used as a diluent or vehicle for a drug. The commissioner shall establish a list of active

206.35 pharmaceutical ingredients and excipients which are included in the medical assistance

207.1 formulary. Medical assistance covers selected active pharmaceutical ingredients and
207.2 excipients used in compounded prescriptions when the compounded combination is
207.3 specifically approved by the commissioner or when a commercially available product:

207.4 (1) is not a therapeutic option for the patient;

207.5 (2) does not exist in the same combination of active ingredients in the same strengths
207.6 as the compounded prescription; and

207.7 (3) cannot be used in place of the active pharmaceutical ingredient in the
207.8 compounded prescription.

207.9 (d) Medical assistance covers the following over-the-counter drugs when prescribed
207.10 by a licensed practitioner or by a licensed pharmacist who meets standards established by
207.11 the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen,
207.12 family planning products, aspirin, insulin, products for the treatment of lice, vitamins for
207.13 adults with documented vitamin deficiencies, vitamins for children under the age of seven
207.14 and pregnant or nursing women, and any other over-the-counter drug identified by the
207.15 commissioner, in consultation with the formulary committee, as necessary, appropriate,
207.16 and cost-effective for the treatment of certain specified chronic diseases, conditions,
207.17 or disorders, and this determination shall not be subject to the requirements of chapter
207.18 14. A pharmacist may prescribe over-the-counter medications as provided under this
207.19 paragraph for purposes of receiving reimbursement under Medicaid. When prescribing
207.20 over-the-counter drugs under this paragraph, licensed pharmacists must consult with
207.21 the recipient to determine necessity, provide drug counseling, review drug therapy
207.22 for potential adverse interactions, and make referrals as needed to other health care
207.23 professionals. Over-the-counter medications must be dispensed in a quantity that is the
207.24 lower of: (1) the number of dosage units contained in the manufacturer's original package;
207.25 and (2) the number of dosage units required to complete the patient's course of therapy.

207.26 (e) Effective January 1, 2006, medical assistance shall not cover drugs that
207.27 are coverable under Medicare Part D as defined in the Medicare Prescription Drug,
207.28 Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e),
207.29 for individuals eligible for drug coverage as defined in the Medicare Prescription
207.30 Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section
207.31 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the
207.32 drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this
207.33 subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code,
207.34 title 42, section 1396r-8(d)(2)(E), shall not be covered.

207.35 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
207.36 Program and dispensed by 340B covered entities and ambulatory pharmacies under

208.1 common ownership of the 340B covered entity. Medical assistance does not cover drugs
208.2 acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract
208.3 pharmacies.

208.4 Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 13e, is amended to
208.5 read:

208.6 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
208.7 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable
208.8 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price
208.9 charged to the public. The amount of payment basis must be reduced to reflect all discount
208.10 amounts applied to the charge by any provider/insurer agreement or contract for submitted
208.11 charges to medical assistance programs. The net submitted charge may not be greater
208.12 than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65,
208.13 except that the dispensing fee for intravenous solutions which must be compounded by
208.14 the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and
208.15 \$30 per bag for total parenteral nutritional products dispensed in one liter quantities,
208.16 or \$44 per bag for total parenteral nutritional products dispensed in quantities greater
208.17 than one liter. Actual acquisition cost includes quantity and other special discounts
208.18 except time and cash discounts. The actual acquisition cost of a drug shall be estimated
208.19 by the commissioner at wholesale acquisition cost plus four percent for independently
208.20 owned pharmacies located in a designated rural area within Minnesota, and at wholesale
208.21 acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently
208.22 owned" if it is one of four or fewer pharmacies under the same ownership nationally. A
208.23 "designated rural area" means an area defined as a small rural area or isolated rural area
208.24 according to the four-category classification of the Rural Urban Commuting Area system
208.25 developed for the United States Health Resources and Services Administration. Effective
208.26 January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B
208.27 Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition
208.28 cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list
208.29 price for a drug or biological to wholesalers or direct purchasers in the United States, not
208.30 including prompt pay or other discounts, rebates, or reductions in price, for the most
208.31 recent month for which information is available, as reported in wholesale price guides or
208.32 other publications of drug or biological pricing data. The maximum allowable cost of a
208.33 multisource drug may be set by the commissioner and it shall be comparable to, but no
208.34 higher than, the maximum amount paid by other third-party payors in this state who have

209.1 maximum allowable cost programs. Establishment of the amount of payment for drugs
209.2 shall not be subject to the requirements of the Administrative Procedure Act.

209.3 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
209.4 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
209.5 facilities when a unit dose blister card system, approved by the department, is used. Under
209.6 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The
209.7 National Drug Code (NDC) from the drug container used to fill the blister card must be
209.8 identified on the claim to the department. The unit dose blister card containing the drug
209.9 must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that
209.10 govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will
209.11 be required to credit the department for the actual acquisition cost of all unused drugs that
209.12 are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in
209.13 a quantity that is less than a 30-day supply.

209.14 (c) Whenever a maximum allowable cost has been set for a multisource drug,
209.15 payment shall be the lower of the usual and customary price charged to the public or the
209.16 maximum allowable cost established by the commissioner unless prior authorization
209.17 for the brand name product has been granted according to the criteria established by
209.18 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the
209.19 prescriber has indicated "dispense as written" on the prescription in a manner consistent
209.20 with section 151.21, subdivision 2.

209.21 (d) The basis for determining the amount of payment for drugs administered in an
209.22 outpatient setting shall be the lower of the usual and customary cost submitted by the
209.23 provider or 106 percent of the average sales price as determined by the United States
209.24 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
209.25 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
209.26 set by the commissioner. If average sales price is unavailable, the amount of payment
209.27 must be lower of the usual and customary cost submitted by the provider or the wholesale
209.28 acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the
209.29 commissioner. Effective January 1, 2014, the commissioner shall discount the payment
209.30 rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The
209.31 payment for drugs administered in an outpatient setting shall be made to the administering
209.32 facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration
209.33 in an outpatient setting is not eligible for direct reimbursement.

209.34 (e) The commissioner may negotiate lower reimbursement rates for specialty
209.35 pharmacy products than the rates specified in paragraph (a). The commissioner may
209.36 require individuals enrolled in the health care programs administered by the department

210.1 to obtain specialty pharmacy products from providers with whom the commissioner has
210.2 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
210.3 used by a small number of recipients or recipients with complex and chronic diseases
210.4 that require expensive and challenging drug regimens. Examples of these conditions
210.5 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
210.6 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
210.7 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
210.8 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
210.9 that require complex care. The commissioner shall consult with the formulary committee
210.10 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
210.11 with the formulary committee in developing this list, the commissioner shall take into
210.12 consideration the population served by specialty pharmacy products, the current delivery
210.13 system and standard of care in the state, and access to care issues. The commissioner shall
210.14 have the discretion to adjust the reimbursement rate to prevent access to care issues.

210.15 (f) Home infusion therapy services provided by home infusion therapy pharmacies
210.16 must be paid at rates according to subdivision 8d.

210.17 **EFFECTIVE DATE.** This section is effective July 1, 2013.

210.18 Sec. 11. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
210.19 subdivision to read:

210.20 **Subd. 28b. Doula services.** Medical assistance covers doula services provided by a
210.21 certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For
210.22 purposes of this section, "doula services" means childbirth education and support services,
210.23 including emotional and physical support provided during pregnancy, labor, birth, and
210.24 postpartum.

210.25 **EFFECTIVE DATE.** This section is effective July 1, 2014, or upon federal
210.26 approval, whichever is later, and applies to services provided on or after the effective date.

210.27 Sec. 12. Minnesota Statutes 2012, section 256B.0625, subdivision 31, is amended to
210.28 read:

210.29 **Subd. 31. Medical supplies and equipment.** (a) Medical assistance covers medical
210.30 supplies and equipment. Separate payment outside of the facility's payment rate shall
210.31 be made for wheelchairs and wheelchair accessories for recipients who are residents
210.32 of intermediate care facilities for the developmentally disabled. Reimbursement for
210.33 wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same

211.1 conditions and limitations as coverage for recipients who do not reside in institutions. A
211.2 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
211.3 The commissioner may set reimbursement rates for specified categories of medical
211.4 supplies at levels below the Medicare payment rate.

211.5 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
211.6 must enroll as a Medicare provider.

211.7 (c) When necessary to ensure access to durable medical equipment, prosthetics,
211.8 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare
211.9 enrollment requirement if:

211.10 (1) the vendor supplies only one type of durable medical equipment, prosthetic,
211.11 orthotic, or medical supply;

211.12 (2) the vendor serves ten or fewer medical assistance recipients per year;

211.13 (3) the commissioner finds that other vendors are not available to provide same or
211.14 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

211.15 (4) the vendor complies with all screening requirements in this chapter and Code of
211.16 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
211.17 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
211.18 and Medicaid Services approved national accreditation organization as complying with
211.19 the Medicare program's supplier and quality standards and the vendor serves primarily
211.20 pediatric patients.

211.21 (d) Durable medical equipment means a device or equipment that:

211.22 (1) can withstand repeated use;

211.23 (2) is generally not useful in the absence of an illness, injury, or disability; and

211.24 (3) is provided to correct or accommodate a physiological disorder or physical
211.25 condition or is generally used primarily for a medical purpose.

211.26 (e) Electronic tablets may be considered durable medical equipment if the electronic
211.27 tablet will be used as an augmentative and alternative communication system as defined
211.28 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device
211.29 must be locked in order to prevent use not related to communication.

211.30 Sec. 13. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
211.31 subdivision to read:

211.32 Subd. 31b. Preferred diabetic testing supply program. (a) The commissioner
211.33 shall implement a point-of-sale preferred diabetic testing supply program by January 1,
211.34 2014. Medical assistance coverage for diabetic testing supplies shall conform to the
211.35 limitations established under the program. The commissioner may enter into a contract

212.1 with a vendor for the purpose of participating in a preferred diabetic testing supply list and
212.2 supplemental rebate program. The commissioner shall ensure that any contract meets all
212.3 federal requirements and maximizes federal financial participation. The commissioner
212.4 shall maintain an accurate and up-to-date list on the department's Web site.

212.5 (b) The commissioner may add to, delete from, and otherwise modify the preferred
212.6 diabetic testing supply program drug list after consulting with the Drug Formulary
212.7 Committee and appropriate medical specialists and providing public notice and the
212.8 opportunity for public comment.

212.9 (c) The commissioner shall adopt and administer the preferred diabetic testing
212.10 supply program as part of the administration of the diabetic testing supply rebate program.
212.11 Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply
212.12 list may be subject to prior authorization.

212.13 (d) All claims for diabetic testing supplies in categories on the preferred diabetic
212.14 testing supply list must be submitted by enrolled pharmacy providers using the most
212.15 current National Council of Prescription Drug Plans electronic claims standard.

212.16 (e) For purposes of this subdivision, "preferred diabetic testing supply list" means a
212.17 list of diabetic testing supplies selected by the commissioner, for which prior authorization
212.18 is not required.

212.19 (f) The commissioner shall seek any federal waivers or approvals necessary to
212.20 implement this subdivision.

212.21 Sec. 14. Minnesota Statutes 2012, section 256B.0625, subdivision 39, is amended to
212.22 read:

212.23 Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines
212.24 within the scope of their licensure, and who are enrolled as a medical assistance provider,
212.25 must enroll in the pediatric vaccine administration program established by section 13631
212.26 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay ~~an~~
212.27 ~~\$8.50 fee per dose~~ for administration of the vaccine to children eligible for medical
212.28 assistance. Medical assistance does not pay for vaccines that are available at no cost from
212.29 the pediatric vaccine administration program.

212.30 Sec. 15. Minnesota Statutes 2012, section 256B.0625, subdivision 58, is amended to
212.31 read:

212.32 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**
212.33 Medical assistance covers early and periodic screening, diagnosis, and treatment services
212.34 (EPSDT). The payment amount for a complete EPSDT screening shall not include charges

213.1 for vaccines that are available at no cost to the provider and shall not exceed the rate
213.2 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

213.3 Sec. 16. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
213.4 subdivision to read:

213.5 Subd. 61. **Payment for multiple services provided on the same day.** The
213.6 commissioner shall not prohibit payment, including supplemental payments, for mental
213.7 health services or dental services provided to a patient by a clinic or health care
213.8 professional solely because the mental health or dental services were provided on the same
213.9 day as other covered health services furnished by the same provider.

213.10 Sec. 17. Minnesota Statutes 2012, section 256B.0631, subdivision 1, is amended to read:

213.11 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
213.12 assistance benefit plan shall include the following cost-sharing for all recipients, effective
213.13 for services provided on or after September 1, 2011:

213.14 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes
213.15 of this subdivision, a visit means an episode of service which is required because of
213.16 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
213.17 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
213.18 midwife, advanced practice nurse, audiologist, optician, or optometrist;

213.19 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that
213.20 this co-payment shall be increased to \$20 upon federal approval;

213.21 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
213.22 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
213.23 shall apply to antipsychotic drugs when used for the treatment of mental illness;

213.24 (4) effective January 1, 2012, a family deductible equal to the maximum amount
213.25 allowed under Code of Federal Regulations, title 42, part 447.54; and

213.26 (5) for individuals identified by the commissioner with income at or below 100
213.27 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five
213.28 percent of family income. For purposes of this paragraph, family income is the total
213.29 earned and unearned income of the individual and the individual's spouse, if the spouse is
213.30 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

213.31 (b) Recipients of medical assistance are responsible for all co-payments and
213.32 deductibles in this subdivision.

213.33 (c) Notwithstanding paragraph (b), the commissioner, through the contracting
213.34 process under sections 256B.69 and 256B.692, may allow managed care plans and

214.1 county-based purchasing plans to waive the family deductible under paragraph (a),
214.2 clause (4). The value of the family deductible shall not be included in the capitation
214.3 payment to managed care plans and county-based purchasing plans. Managed care plans
214.4 and county-based purchasing plans shall certify annually to the commissioner the dollar
214.5 value of the family deductible.

214.6 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of
214.7 the family deductible described under paragraph (a), clause (4), from individuals and
214.8 allow long-term care and waived service providers to assume responsibility for payment.

214.9 (e) Notwithstanding paragraph (b), the commissioner, through the contracting
214.10 process under section 256B.0756 shall allow the pilot program in Hennepin County to
214.11 waive co-payments. The value of the co-payments shall not be included in the capitation
214.12 payment amount to the integrated health care delivery networks under the pilot program.

214.13 Sec. 18. Minnesota Statutes 2012, section 256B.0756, is amended to read:

214.14 **256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.**

214.15 (a) The commissioner, upon federal approval of a new waiver request or amendment
214.16 of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey
214.17 County, or both, to test alternative and innovative integrated health care delivery networks.

214.18 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
214.19 medical assistance under section 256B.055, ~~subdivision 15~~, and who reside in Hennepin
214.20 County or Ramsey County. The commissioner may identify individuals to be enrolled in
214.21 the Hennepin County pilot program based on zip code in Hennepin County or whether the
214.22 individuals would benefit from an integrated health care delivery network.

214.23 (c) Individuals enrolled in the pilot program shall be enrolled in an integrated
214.24 health care delivery network in their county of residence. The integrated health care
214.25 delivery network in Hennepin County shall be a network, such as an accountable care
214.26 organization or a community-based collaborative care network, created by or including
214.27 Hennepin County Medical Center. The integrated health care delivery network in Ramsey
214.28 County shall be a network, such as an accountable care organization or community-based
214.29 collaborative care network, created by or including Regions Hospital.

214.30 ~~(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for~~
214.31 ~~Hennepin County and 3,500 enrollees for Ramsey County.~~

214.32 ~~(e)~~ (d) In developing a payment system for the pilot programs, the commissioner
214.33 shall establish a total cost of care for the recipients enrolled in the pilot programs that
214.34 equals the cost of care that would otherwise be spent for these enrollees in the prepaid
214.35 medical assistance program.

215.1 ~~(f) Counties may transfer funds necessary to support the nonfederal share of~~
215.2 ~~payments for integrated health care delivery networks in their county. Such transfers per~~
215.3 ~~county shall not exceed 15 percent of the expected expenses for county enrollees.~~

215.4 ~~(g)~~ (e) The commissioner shall apply to the federal government for, or as appropriate,
215.5 cooperate with counties, providers, or other entities that are applying for any applicable
215.6 grant or demonstration under the Patient Protection and Affordable Health Care Act, Public
215.7 Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law
215.8 111-152, that would further the purposes of or assist in the creation of an integrated health
215.9 care delivery network for the purposes of this subdivision, including, but not limited to, a
215.10 global payment demonstration or the community-based collaborative care network grants.

215.11 Sec. 19. Minnesota Statutes 2012, section 256B.196, subdivision 2, is amended to read:

215.12 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and
215.13 subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital
215.14 services upper payment limit for nonstate government hospitals. The commissioner shall
215.15 then determine the amount of a supplemental payment to Hennepin County Medical
215.16 Center and Regions Hospital for these services that would increase medical assistance
215.17 spending in this category to the aggregate upper payment limit for all nonstate government
215.18 hospitals in Minnesota. In making this determination, the commissioner shall allot the
215.19 available increases between Hennepin County Medical Center and Regions Hospital
215.20 based on the ratio of medical assistance fee-for-service outpatient hospital payments to
215.21 the two facilities. The commissioner shall adjust this allotment as necessary based on
215.22 federal approvals, the amount of intergovernmental transfers received from Hennepin and
215.23 Ramsey Counties, and other factors, in order to maximize the additional total payments.
215.24 The commissioner shall inform Hennepin County and Ramsey County of the periodic
215.25 intergovernmental transfers necessary to match federal Medicaid payments available
215.26 under this subdivision in order to make supplementary medical assistance payments to
215.27 Hennepin County Medical Center and Regions Hospital equal to an amount that when
215.28 combined with existing medical assistance payments to nonstate governmental hospitals
215.29 would increase total payments to hospitals in this category for outpatient services to
215.30 the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon
215.31 receipt of these periodic transfers, the commissioner shall make supplementary payments
215.32 to Hennepin County Medical Center and Regions Hospital.

215.33 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
215.34 determine an upper payment limit for physicians and other billing professionals affiliated
215.35 with Hennepin County Medical Center and with Regions Hospital. The upper payment

216.1 limit shall be based on the average commercial rate or be determined using another method
216.2 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall
216.3 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers
216.4 necessary to match the federal Medicaid payments available under this subdivision in order
216.5 to make supplementary payments to physicians and other billing professionals affiliated
216.6 with Hennepin County Medical Center and to make supplementary payments to physicians
216.7 and other billing professionals affiliated with Regions Hospital through HealthPartners
216.8 Medical Group equal to the difference between the established medical assistance
216.9 payment for physician and other billing professional services and the upper payment limit.
216.10 Upon receipt of these periodic transfers, the commissioner shall make supplementary
216.11 payments to physicians and other billing professionals affiliated with Hennepin County
216.12 Medical Center and shall make supplementary payments to physicians and other billing
216.13 professionals affiliated with Regions Hospital through HealthPartners Medical Group.

216.14 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make
216.15 monthly voluntary intergovernmental transfers to the commissioner in amounts not to
216.16 exceed \$12,000,000 per year from Hennepin County and \$6,000,000 per year from
216.17 Ramsey County. The commissioner shall increase the medical assistance capitation
216.18 payments to any licensed health plan under contract with the medical assistance program
216.19 that agrees to make enhanced payments to Hennepin County Medical Center or Regions
216.20 Hospital. The increase shall be in an amount equal to the annual value of the monthly
216.21 transfers plus federal financial participation, with each health plan receiving its pro rata
216.22 share of the increase based on the pro rata share of medical assistance admissions to
216.23 Hennepin County Medical Center and Regions Hospital by those plans. Upon the request
216.24 of the commissioner, health plans shall submit individual-level cost data for verification
216.25 purposes. The commissioner may ratably reduce these payments on a pro rata basis in
216.26 order to satisfy federal requirements for actuarial soundness. If payments are reduced,
216.27 transfers shall be reduced accordingly. Any licensed health plan that receives increased
216.28 medical assistance capitation payments under the intergovernmental transfer described in
216.29 this paragraph shall increase its medical assistance payments to Hennepin County Medical
216.30 Center and Regions Hospital by the same amount as the increased payments received in
216.31 the capitation payment described in this paragraph.

216.32 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall
216.33 determine an upper payment limit for ambulance services affiliated with Hennepin County
216.34 Medical Center and the city of St. Paul. The upper payment limit shall be based on
216.35 the average commercial rate or be determined using another method acceptable to the
216.36 Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin

217.1 County and the city of St. Paul of the periodic intergovernmental transfers necessary to
217.2 match the federal Medicaid payments available under this subdivision in order to make
217.3 supplementary payments to Hennepin County Medical Center and the city of St. Paul
217.4 equal to the difference between the established medical assistance payment for ambulance
217.5 services and the upper payment limit. Upon receipt of these periodic transfers, the
217.6 commissioner shall make supplementary payments to Hennepin County Medical Center
217.7 and the city of St. Paul.

217.8 (e) The commissioner shall inform the transferring governmental entities on an
217.9 ongoing basis of the need for any changes needed in the intergovernmental transfers in
217.10 order to continue the payments under paragraphs (a) to ~~(e)~~ (d), at their maximum level,
217.11 including increases in upper payment limits, changes in the federal Medicaid match, and
217.12 other factors.

217.13 ~~(e)~~ (f) The payments in paragraphs (a) to ~~(e)~~ (d) shall be implemented independently
217.14 of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

217.15 Sec. 20. Minnesota Statutes 2012, section 256B.69, subdivision 5c, is amended to read:

217.16 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
217.17 services shall transfer each year to the medical education and research fund established
217.18 under section 62J.692, an amount specified in this subdivision. The commissioner shall
217.19 calculate the following:

217.20 (1) an amount equal to the reduction in the prepaid medical assistance payments as
217.21 specified in this clause. Until January 1, 2002, the county medical assistance capitation
217.22 base rate prior to plan specific adjustments and after the regional rate adjustments under
217.23 subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining
217.24 metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after
217.25 January 1, 2002, the county medical assistance capitation base rate prior to plan specific
217.26 adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining
217.27 metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing
217.28 facility and elderly waiver payments and demonstration project payments operating
217.29 under subdivision 23 are excluded from this reduction. The amount calculated under
217.30 this clause shall not be adjusted for periods already paid due to subsequent changes to
217.31 the capitation payments;

217.32 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this
217.33 section;

217.34 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates
217.35 paid under this section; and

218.1 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid
218.2 under this section.

218.3 (b) This subdivision shall be effective upon approval of a federal waiver which
218.4 allows federal financial participation in the medical education and research fund. The
218.5 amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount
218.6 transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under
218.7 paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally
218.8 reduce the amount specified under paragraph (a), clause (1).

218.9 (c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner
218.10 shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

218.11 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the
218.12 transfer under paragraph (c), the commissioner shall transfer to the medical education
218.13 research fund \$23,936,000 in fiscal years 2012 and 2013 and ~~\$36,744,000~~ \$49,552,000 in
218.14 fiscal year 2014 and thereafter.

218.15 Sec. 21. Minnesota Statutes 2012, section 256B.69, subdivision 5i, is amended to read:

218.16 Subd. 5i. **Administrative expenses.** (a) Managed care plan and county-based
218.17 purchasing plan administrative costs for a prepaid health plan provided under this section
218.18 or section 256B.692 must not exceed by more than five percent that prepaid health plan's
218.19 or county-based purchasing plan's actual calculated administrative spending for the
218.20 previous calendar year as a percentage of total revenue. The penalty for exceeding this
218.21 limit must be the amount of administrative spending in excess of 105 percent of the actual
218.22 calculated amount. The commissioner may waive this penalty if the excess administrative
218.23 spending is the result of unexpected shifts in enrollment or member needs or new program
218.24 requirements.

218.25 ~~(b) Expenses listed under section 62D.12, subdivision 9a, clause (4), are not~~
218.26 ~~allowable administrative expenses for rate-setting purposes under this section, unless~~
218.27 ~~approved by the commissioner. The following expenses are not allowable administrative~~
218.28 ~~expenses for rate-setting purposes under this section:~~

218.29 (1) charitable contributions made by the managed care plan or the county-based
218.30 purchasing plan;

218.31 (2) any portion of an individual's compensation in excess of \$200,000 paid by the
218.32 managed care plan or county-based purchasing plan;

218.33 (3) any penalties or fines assessed against the managed care plan or county-based
218.34 purchasing plan; and

219.1 (4) any indirect marketing or advertising expenses of the managed care plan or
219.2 county-based purchasing plan.

219.3 For the purposes of this subdivision, compensation includes salaries, bonuses and
219.4 incentives, other reportable compensation on an IRS 990 form, retirement and other
219.5 deferred compensation, and nontaxable benefits.

219.6 Sec. 22. Minnesota Statutes 2012, section 256B.69, subdivision 9c, is amended to read:

219.7 Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect
219.8 detailed data regarding financials, provider payments, provider rate methodologies, and
219.9 other data as determined by the commissioner ~~and managed care and county-based~~
219.10 ~~purchasing plans that are required to be submitted under this section.~~ The commissioner,
219.11 in consultation with the commissioners of health and commerce, and in consultation
219.12 with managed care plans and county-based purchasing plans, shall set uniform criteria,
219.13 definitions, and standards for the data to be submitted, and shall require managed care and
219.14 county-based purchasing plans to comply with these criteria, definitions, and standards
219.15 when submitting data under this section. In carrying out the responsibilities of this
219.16 subdivision, the commissioner shall ensure that the data collection is implemented in an
219.17 integrated and coordinated manner that avoids unnecessary duplication of effort. To the
219.18 extent possible, the commissioner shall use existing data sources and streamline data
219.19 collection in order to reduce public and private sector administrative costs. Nothing in
219.20 this subdivision shall allow release of information that is nonpublic data pursuant to
219.21 section 13.02.

219.22 (b) Effective January 1, 2014, each managed care and county-based purchasing plan
219.23 must ~~annually~~ quarterly provide to the commissioner the following information on state
219.24 public programs, in the form and manner specified by the commissioner, according to
219.25 guidelines developed by the commissioner in consultation with managed care plans and
219.26 county-based purchasing plans under contract:

219.27 (1) an income statement by program;

219.28 (2) financial statement footnotes;

219.29 (3) quarterly profitability by program and population group;

219.30 (4) a medical liability summary by program and population group;

219.31 (5) received but unpaid claims report by program;

219.32 (6) services versus payment lags by program for hospital services, outpatient
219.33 services, physician services, other medical services, and pharmaceutical benefits;

220.1 (7) utilization reports that summarize utilization and unit cost information by
220.2 program for hospitalization services, outpatient services, physician services, and other
220.3 medical services;

220.4 (8) pharmaceutical statistics by program and population group for measures of price
220.5 and utilization of pharmaceutical services;

220.6 (9) subcapitation expenses by population group;

220.7 (10) third-party payments by program;

220.8 (11) all new, active, and closed subrogation cases by program;

220.9 (12) all new, active, and closed fraud and abuse cases by program;

220.10 (13) medical loss ratios by program;

220.11 ~~(14)~~ (14) administrative expenses by category and subcategory consistent with
220.12 administrative expense reporting by program that reconcile to other state and federal
220.13 regulatory agencies, by program;

220.14 ~~(15)~~ (15) revenues by program, including investment income;

220.15 ~~(16)~~ (16) nonadministrative service payments, provider payments, and reimbursement
220.16 rates by provider type or service category, by program, paid by the managed care plan
220.17 under this section or the county-based purchasing plan under section 256B.692 to
220.18 providers and vendors for administrative services under contract with the plan, including
220.19 but not limited to:

220.20 (i) individual-level provider payment and reimbursement rate data;

220.21 (ii) provider reimbursement rate methodologies by provider type, by program,
220.22 including a description of alternative payment arrangements and payments outside the
220.23 claims process;

220.24 (iii) data on implementation of legislatively mandated provider rate changes; and

220.25 (iv) individual-level provider payment and reimbursement rate data and plan-specific
220.26 provider reimbursement rate methodologies by provider type, by program, including
220.27 alternative payment arrangements and payments outside the claims process, provided to
220.28 the commissioner under this subdivision are nonpublic data as defined in section 13.02;

220.29 ~~(17)~~ (17) data on the amount of reinsurance or transfer of risk by program; and

220.30 ~~(18)~~ (18) contribution to reserve, by program.

220.31 (c) In the event a report is published or released based on data provided under
220.32 this subdivision, the commissioner shall provide the report to managed care plans and
220.33 county-based purchasing plans ~~30~~ 15 days prior to the publication or release of the report.
220.34 Managed care plans and county-based purchasing plans shall have ~~30~~ 15 days to review
220.35 the report and provide comment to the commissioner.

221.1 The quarterly reports shall be submitted to the commissioner no later than 60 days after the
221.2 end of the previous quarter, except the fourth-quarter report, which shall be submitted by
221.3 April 1 of each year. The fourth-quarter report shall include audited financial statements,
221.4 parent company audited financial statements, an income statement reconciliation report,
221.5 and any other documentation necessary to reconcile the detailed reports to the audited
221.6 financial statements.

221.7 Sec. 23. Minnesota Statutes 2012, section 256B.69, subdivision 31, is amended to read:

221.8 Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner
221.9 shall reduce payments and limit future rate increases paid to managed care plans and
221.10 county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved
221.11 on a statewide aggregate basis by program. The commissioner may use competitive
221.12 bidding, payment reductions, or other reductions to achieve the reductions and limits
221.13 in this subdivision.

221.14 (b) Beginning September 1, 2011, the commissioner shall reduce payments to
221.15 managed care plans and county-based purchasing plans as follows:

221.16 (1) 2.0 percent for medical assistance elderly basic care. This shall not apply
221.17 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
221.18 services;

221.19 (2) 2.82 percent for medical assistance families and children;

221.20 (3) 10.1 percent for medical assistance adults without children; and

221.21 (4) 6.0 percent for MinnesotaCare families and children.

221.22 (c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed
221.23 care plans and county-based purchasing plans for calendar year 2012 to a percentage of
221.24 the rates in effect on August 31, 2011, as follows:

221.25 (1) 98 percent for medical assistance elderly basic care. This shall not apply to
221.26 Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
221.27 services;

221.28 (2) 97.18 percent for medical assistance families and children;

221.29 (3) 89.9 percent for medical assistance adults without children; and

221.30 (4) 94 percent for MinnesotaCare families and children.

221.31 (d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit
221.32 the maximum annual trend increases to rates paid to managed care plans and county-based
221.33 purchasing plans as follows:

222.1 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply
222.2 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
222.3 services;

222.4 (2) 5.0 percent for medical assistance special needs basic care;

222.5 (3) 2.0 percent for medical assistance families and children;

222.6 (4) 3.0 percent for medical assistance adults without children;

222.7 (5) 3.0 percent for MinnesotaCare families and children; and

222.8 (6) 3.0 percent for MinnesotaCare adults without children.

222.9 (e) The commissioner may limit trend increases to less than the maximum.

222.10 Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases
222.11 to rates paid to managed care plans and county-based purchasing plans as follows for
222.12 calendar years 2014 and 2015:

222.13 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply
222.14 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
222.15 services;

222.16 (2) 5.0 percent for medical assistance special needs basic care;

222.17 (3) 2.0 percent for medical assistance families and children;

222.18 (4) 3.0 percent for medical assistance adults without children;

222.19 (5) 3.0 percent for MinnesotaCare families and children; and

222.20 (6) 4.0 percent for MinnesotaCare adults without children.

222.21 The commissioner may limit trend increases to less than the maximum. For calendar
222.22 year 2014, the commissioner shall reduce the maximum aggregate trend increases by
222.23 \$47,000,000 in state and federal funds to account for the reductions in administrative
222.24 expenses in subdivision 5i.

222.25 Sec. 24. Minnesota Statutes 2012, section 256B.69, is amended by adding a
222.26 subdivision to read:

222.27 Subd. 35. **Supplemental recovery program.** The commissioner shall conduct a
222.28 supplemental recovery program for third-party liabilities not recovered by managed care
222.29 plans and county-based purchasing plans for state public health programs. Any third-party
222.30 liability identified and recovered by the commissioner more than six months after the date
222.31 a managed care plan or county-based purchasing plan receives a health care claim shall
222.32 be retained by the commissioner and deposited in the general fund. The commissioner
222.33 shall establish a mechanism for managed care plans and county-based purchasing plans to
222.34 coordinate third-party liability collections efforts with the commissioner to ensure there

223.1 is no duplication of efforts. The coordination mechanism must be consistent with the
223.2 reporting requirements in subdivision 9c.

223.3 Sec. 25. Minnesota Statutes 2012, section 256B.76, subdivision 1, is amended to read:

223.4 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
223.5 or after October 1, 1992, the commissioner shall make payments for physician services
223.6 as follows:

223.7 (1) payment for level one Centers for Medicare and Medicaid Services' common
223.8 procedural coding system codes titled "office and other outpatient services," "preventive
223.9 medicine new and established patient," "delivery, antepartum, and postpartum care,"
223.10 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
223.11 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
223.12 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
223.13 30, 1992. If the rate on any procedure code within these categories is different than the
223.14 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
223.15 then the larger rate shall be paid;

223.16 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
223.17 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

223.18 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
223.19 percentile of 1989, less the percent in aggregate necessary to equal the above increases
223.20 except that payment rates for home health agency services shall be the rates in effect
223.21 on September 30, 1992.

223.22 (b) Effective for services rendered on or after January 1, 2000, payment rates for
223.23 physician and professional services shall be increased by three percent over the rates
223.24 in effect on December 31, 1999, except for home health agency and family planning
223.25 agency services. The increases in this paragraph shall be implemented January 1, 2000,
223.26 for managed care.

223.27 (c) Effective for services rendered on or after July 1, 2009, payment rates for
223.28 physician and professional services shall be reduced by five percent, except that for the
223.29 period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent
223.30 for the medical assistance and general assistance medical care programs, over the rates in
223.31 effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply
223.32 to office or other outpatient visits, preventive medicine visits and family planning visits
223.33 billed by physicians, advanced practice nurses, or physician assistants in a family planning
223.34 agency or in one of the following primary care practices: general practice, general internal
223.35 medicine, general pediatrics, general geriatrics, and family medicine. This reduction

224.1 and the reductions in paragraph (d) do not apply to federally qualified health centers,
224.2 rural health centers, and Indian health services. Effective October 1, 2009, payments
224.3 made to managed care plans and county-based purchasing plans under sections 256B.69,
224.4 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

224.5 (d) Effective for services rendered on or after July 1, 2010, payment rates for
224.6 physician and professional services shall be reduced an additional seven percent over
224.7 the five percent reduction in rates described in paragraph (c). This additional reduction
224.8 does not apply to physical therapy services, occupational therapy services, and speech
224.9 pathology and related services provided on or after July 1, 2010. This additional reduction
224.10 does not apply to physician services billed by a psychiatrist or an advanced practice nurse
224.11 with a specialty in mental health. Effective October 1, 2010, payments made to managed
224.12 care plans and county-based purchasing plans under sections 256B.69, 256B.692, and
224.13 256L.12 shall reflect the payment reduction described in this paragraph.

224.14 (e) Effective for services rendered on or after September 1, 2011, through June 30,
224.15 2013, payment rates for physician and professional services shall be reduced three percent
224.16 from the rates in effect on August 31, 2011. This reduction does not apply to physical
224.17 therapy services, occupational therapy services, and speech pathology and related services.

224.18 (f) Effective for services rendered on or after September 1, 2014, payment rates for
224.19 physician and professional services, including physical therapy, occupational therapy,
224.20 speech pathology, and mental health services shall be increased by five percent from the
224.21 rates in effect on August 31, 2014. In calculating this rate increase, the commissioner
224.22 shall not include in the base rate for August 31, 2014, the rate increase provided under
224.23 section 256B.76, subdivision 7. This increase does not apply to federally qualified health
224.24 centers, rural health centers, and Indian health services. Payments made to managed
224.25 care plans and county-based purchasing plans shall not be adjusted to reflect payments
224.26 under this paragraph.

224.27 Sec. 26. Minnesota Statutes 2012, section 256B.76, subdivision 2, is amended to read:

224.28 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after
224.29 October 1, 1992, the commissioner shall make payments for dental services as follows:

224.30 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
224.31 percent above the rate in effect on June 30, 1992; and

224.32 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
224.33 percentile of 1989, less the percent in aggregate necessary to equal the above increases.

224.34 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
224.35 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

225.1 (c) Effective for services rendered on or after January 1, 2000, payment rates for
225.2 dental services shall be increased by three percent over the rates in effect on December
225.3 31, 1999.

225.4 (d) Effective for services provided on or after January 1, 2002, payment for
225.5 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
225.6 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

225.7 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
225.8 2000, for managed care.

225.9 (f) Effective for dental services rendered on or after October 1, 2010, by a
225.10 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based
225.11 on the Medicare principles of reimbursement. This payment shall be effective for services
225.12 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
225.13 county-based purchasing plans.

225.14 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
225.15 in paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal
225.16 year, a supplemental state payment equal to the difference between the total payments
225.17 in paragraph (f) and \$1,850,000 shall be paid from the general fund to state-operated
225.18 services for the operation of the dental clinics.

225.19 (h) If the cost-based payment system for state-operated dental clinics described in
225.20 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
225.21 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
225.22 receive the critical access dental reimbursement rate as described under subdivision 4,
225.23 paragraph (a).

225.24 (i) Effective for services rendered on or after September 1, 2011, through June 30,
225.25 2013, payment rates for dental services shall be reduced by three percent. This reduction
225.26 does not apply to state-operated dental clinics in paragraph (f).

225.27 (j) Effective for services rendered on or after January 1, 2014, payment rates for
225.28 dental services shall be increased by five percent from the rates in effect on December
225.29 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),
225.30 federally qualified health centers, rural health centers, and Indian health services. Effective
225.31 January 1, 2014, payments made to managed care plans and county-based purchasing
225.32 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
225.33 described in this paragraph.

225.34 Sec. 27. Minnesota Statutes 2012, section 256B.76, subdivision 4, is amended to read:

226.1 Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered
226.2 on or after January 1, 2002, the commissioner shall increase reimbursements to dentists
226.3 and dental clinics deemed by the commissioner to be critical access dental providers.
226.4 For dental services rendered on or after July 1, 2007, the commissioner shall increase
226.5 reimbursement by ~~30~~ 35 percent above the reimbursement rate that would otherwise be
226.6 paid to the critical access dental provider. The commissioner shall pay the managed
226.7 care plans and county-based purchasing plans in amounts sufficient to reflect increased
226.8 reimbursements to critical access dental providers as approved by the commissioner.

226.9 (b) The commissioner shall designate the following dentists and dental clinics as
226.10 critical access dental providers:

226.11 (1) nonprofit community clinics that:

226.12 (i) have nonprofit status in accordance with chapter 317A;

226.13 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
226.14 501(c)(3);

226.15 (iii) are established to provide oral health services to patients who are low income,
226.16 uninsured, have special needs, and are underserved;

226.17 (iv) have professional staff familiar with the cultural background of the clinic's
226.18 patients;

226.19 (v) charge for services on a sliding fee scale designed to provide assistance to
226.20 low-income patients based on current poverty income guidelines and family size;

226.21 (vi) do not restrict access or services because of a patient's financial limitations
226.22 or public assistance status; and

226.23 (vii) have free care available as needed;

226.24 (2) federally qualified health centers, rural health clinics, and public health clinics;

226.25 (3) city or county owned and operated hospital-based dental clinics;

226.26 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
226.27 accordance with chapter 317A with more than 10,000 patient encounters per year with
226.28 patients who are uninsured or covered by medical assistance, ~~general assistance medical~~
226.29 ~~care~~, or MinnesotaCare; ~~and~~

226.30 (5) a dental clinic owned and operated by the University of Minnesota or the
226.31 Minnesota State Colleges and Universities system; and

226.32 (6) private practicing dentists if:

226.33 (i) the dentist's office is located within a health professional shortage area as defined
226.34 under Code of Federal Regulations, title 42, part 5, and United States Code, title 42,
226.35 section 254E;

227.1 (ii) more than 50 percent of the dentist's patient encounters per year are with patients
227.2 who are uninsured or covered by medical assistance or MinnesotaCare;

227.3 (iii) the dentist does not restrict access or services because of a patient's financial
227.4 limitations or public assistance status; and

227.5 (iv) the level of service provided by the dentist is critical to maintaining adequate
227.6 levels of patient access within the service area in which the dentist operates.

227.7 ~~(e) The commissioner may designate a dentist or dental clinic as a critical access~~
227.8 ~~dental provider if the dentist or dental clinic is willing to provide care to patients covered~~
227.9 ~~by medical assistance, general assistance medical care, or MinnesotaCare at a level which~~
227.10 ~~significantly increases access to dental care in the service area.~~

227.11 ~~(d)~~ (c) A designated critical access clinic shall receive the reimbursement rate
227.12 specified in paragraph (a) for dental services provided off site at a private dental office if
227.13 the following requirements are met:

227.14 (1) the designated critical access dental clinic is located within a health professional
227.15 shortage area as defined under Code of Federal Regulations, title 42, part 5, and United
227.16 States Code, title 42, section 254E, and is located outside the seven-county metropolitan
227.17 area;

227.18 (2) the designated critical access dental clinic is not able to provide the service
227.19 and refers the patient to the off-site dentist;

227.20 (3) the service, if provided at the critical access dental clinic, would be reimbursed
227.21 at the critical access reimbursement rate;

227.22 (4) the dentist and allied dental professionals providing the services off site are
227.23 licensed and in good standing under chapter 150A;

227.24 (5) the dentist providing the services is enrolled as a medical assistance provider;

227.25 (6) the critical access dental clinic submits the claim for services provided off site
227.26 and receives the payment for the services; and

227.27 (7) the critical access dental clinic maintains dental records for each claim submitted
227.28 under this paragraph, including the name of the dentist, the off-site location, and the
227.29 license number of the dentist and allied dental professionals providing the services.

227.30 Sec. 28. Minnesota Statutes 2012, section 256B.76, is amended by adding a
227.31 subdivision to read:

227.32 Subd. 7. **Payment for certain primary care services and immunization**
227.33 **administration.** Payment for certain primary care services and immunization
227.34 administration services rendered on or after January 1, 2013, through December 31, 2014,
227.35 shall be made in accordance with section 1902(a)(13) of the Social Security Act.

228.1 Sec. 29. Minnesota Statutes 2012, section 256B.764, is amended to read:

228.2 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

228.3 (a) Effective for services rendered on or after July 1, 2007, payment rates for family
228.4 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,
228.5 when these services are provided by a community clinic as defined in section 145.9268,
228.6 subdivision 1.

228.7 (b) Effective for services rendered on or after July 1, 2013, payment rates for
228.8 family planning services shall be increased by 20 percent over the rates in effect June
228.9 30, 2013, when these services are provided by a community clinic as defined in section
228.10 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care
228.11 and county-based purchasing plans to reflect this increase, and shall require plans to pass
228.12 on the full amount of the rate increase to eligible community clinics, in the form of higher
228.13 payment rates for family planning services.

228.14 Sec. 30. Minnesota Statutes 2012, section 256B.766, is amended to read:

228.15 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

228.16 (a) Effective for services provided on or after July 1, 2009, total payments for basic
228.17 care services, shall be reduced by three percent, except that for the period July 1, 2009,
228.18 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
228.19 assistance and general assistance medical care programs, prior to third-party liability and
228.20 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
228.21 therapy services, occupational therapy services, and speech-language pathology and
228.22 related services as basic care services. The reduction in this paragraph shall apply to
228.23 physical therapy services, occupational therapy services, and speech-language pathology
228.24 and related services provided on or after July 1, 2010.

228.25 (b) Payments made to managed care plans and county-based purchasing plans shall
228.26 be reduced for services provided on or after October 1, 2009, to reflect the reduction
228.27 effective July 1, 2009, and payments made to the plans shall be reduced effective October
228.28 1, 2010, to reflect the reduction effective July 1, 2010.

228.29 (c) Effective for services provided on or after September 1, 2011, through June 30,
228.30 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
228.31 from the rates in effect on August 31, 2011.

228.32 (d) Effective for services provided on or after September 1, 2011, through June
228.33 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
228.34 and durable medical equipment not subject to a volume purchase contract, prosthetics
228.35 and orthotics, renal dialysis services, laboratory services, public health nursing services,

229.1 physical therapy services, occupational therapy services, speech therapy services,
229.2 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
229.3 purchase contract, and anesthesia services, and hospice services shall be reduced by three
229.4 percent from the rates in effect on August 31, 2011.

229.5 (e) Effective for services provided on or after September 1, 2014, payments for
229.6 ambulatory surgery centers facility fees, medical supplies and durable medical equipment
229.7 not subject to a volume purchase contract, prosthetics and orthotics, hospice services, renal
229.8 dialysis services, laboratory services, public health nursing services, eyeglasses not subject
229.9 to a volume purchase contract, and hearing aids not subject to a volume purchase contract
229.10 shall be increased by three percent and payments for outpatient hospital facility fees shall
229.11 be increased by three percent. Payments made to managed care plans and county-based
229.12 purchasing plans shall not be adjusted to reflect payments under this paragraph.

229.13 ~~(e)~~ (f) This section does not apply to physician and professional services, inpatient
229.14 hospital services, family planning services, mental health services, dental services,
229.15 prescription drugs, medical transportation, federally qualified health centers, rural health
229.16 centers, Indian health services, and Medicare cost-sharing.

229.17 Sec. 31. Minnesota Statutes 2012, section 256B.767, is amended to read:

229.18 **256B.767 MEDICARE PAYMENT LIMIT.**

229.19 (a) Effective for services rendered on or after July 1, 2010, fee-for-service payment
229.20 rates for physician and professional services under section 256B.76, subdivision 1, and
229.21 basic care services subject to the rate reduction specified in section 256B.766, shall not
229.22 exceed the Medicare payment rate for the applicable service, as adjusted for any changes
229.23 in Medicare payment rates after July 1, 2010. The commissioner shall implement this
229.24 section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates
229.25 under this section by first reducing or eliminating provider rate add-ons.

229.26 (b) This section does not apply to services provided by advanced practice certified
229.27 nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter
229.28 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates
229.29 for advanced practice certified nurse midwives and licensed traditional midwives shall
229.30 equal and shall not exceed the medical assistance payment rate to physicians for the
229.31 applicable service.

229.32 (c) This section does not apply to mental health services or physician services billed
229.33 by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

229.34 (d) Effective for durable medical equipment, prosthetics, orthotics, or supplies
229.35 provided on or after July 1, 2013, through June 30, 2014, the payment rate for items

230.1 that are subject to the rates established under Medicare's National Competitive Bidding
230.2 Program shall be equal to the rate that applies to the same item when not subject to the
230.3 rate established under Medicare's National Competitive Bidding Program. This paragraph
230.4 does not apply to mail order diabetic supplies and does not apply to items provided to
230.5 dually eligible recipients when Medicare is the primary payer of the item.

230.6 Sec. 32. Laws 2013, chapter 1, section 6, is amended to read:

230.7 Sec. 6. **TRANSFER.**

230.8 (a) The commissioner of management and budget shall transfer from the health care
230.9 access fund to the general fund up to \$21,319,000 in fiscal year 2014; up to \$42,314,000
230.10 in fiscal year 2015; up to \$56,147,000 in fiscal year 2016; and up to \$64,683,000 in fiscal
230.11 year 2017.

230.12 (b) The commissioner of human services shall determine the difference between the
230.13 actual or forecasted cost to the medical assistance program of adding 19- and 20-year-olds
230.14 and parents and relative caretaker populations with income between 100 and 138 percent of
230.15 the federal poverty guidelines and the cost of adding those populations that was estimated
230.16 during the 2013 legislative session based on the data from the February 2013 forecast.

230.17 (c) For each fiscal year from 2014 to 2017, the commissioner of human services
230.18 shall certify and report to the commissioner of management and budget the actual
230.19 or forecasted cost difference of adding 19- and 20-year-olds and parents and relative
230.20 caretaker populations with income between 100 and 138 percent of the federal poverty
230.21 guidelines, as determined under paragraph (b), to the commissioner of management and
230.22 budget at least four weeks prior to the release of a forecast under Minnesota Statutes,
230.23 section 16A.103, of each fiscal year.

230.24 (d) No later than three weeks before the release of the forecast under Minnesota
230.25 Statutes, section 16A.103, the commissioner of management and budget shall reduce the
230.26 health care access fund transfer in paragraph (a), by the cumulative differences in costs
230.27 reported by the commissioner of human services under paragraph (c). If, for any fiscal
230.28 year, the amount of the cumulative cost differences determined under paragraph (b) is
230.29 positive, no change is made to the appropriation. If, for any fiscal year, the amount of the
230.30 cumulative cost differences determined under paragraph (b) is less than the amount of the
230.31 original appropriation, the appropriation for that year must be zero.

230.32 Sec. 33. **REQUEST FOR INFORMATION; EMERGENCY MEDICAL**
230.33 **ASSISTANCE AND THE UNINSURED STUDY.**

231.1 (a) The commissioner of human services, in consultation with safety net hospitals,
231.2 nonprofit health care coverage programs, nonprofit community clinics, counties, and other
231.3 interested parties, shall identify alternatives and make recommendations for providing
231.4 coordinated and cost-effective health care and coverage to individuals who:

231.5 (1) meet eligibility standards for emergency medical assistance; or

231.6 (2) are uninsured and ineligible for other state public health care programs, have
231.7 incomes below 400 percent of the federal poverty level, and are ineligible for premium
231.8 credits through the Minnesota Insurance Marketplace as defined under Minnesota Statutes,
231.9 section 62V.02.

231.10 (b) The commissioner of human services shall issue a request for information
231.11 to help identify options for coverage of medically necessary services not eligible for
231.12 federal financial participation for emergency medical assistance recipients and medically
231.13 necessary services for individuals who are uninsured and ineligible for other state public
231.14 health care programs or coverage through the Minnesota Insurance Marketplace. The
231.15 request for information shall provide:

231.16 (1) the identification of services, including community-based medical, dental, and
231.17 behavioral health services, necessary to reduce emergency department and inpatient
231.18 hospital utilization for these recipients;

231.19 (2) delivery system options, including for each option how the system would be
231.20 organized to promote care coordination and cost-effectiveness, and how the system would
231.21 be available statewide;

231.22 (3) funding options and payment mechanisms to encourage providers to manage
231.23 the delivery of care to these populations at a lower cost of care and with better patient
231.24 outcomes than the current system;

231.25 (4) how the funding and delivery of services will be coordinated with the services
231.26 covered under emergency medical assistance;

231.27 (5) options for administration of eligibility determination and service delivery; and

231.28 (6) evaluation methods to measure cost-effectiveness and health outcomes that take
231.29 into consideration the social determinants of health care for recipients participating in
231.30 this alternative coverage option.

231.31 (c) The commissioner shall issue a request for information by August 1, 2013, and
231.32 respondents to the request must submit information to the commissioner by October
231.33 1, 2013.

231.34 (d) The commissioner shall incorporate the information obtained through the request
231.35 for information described in paragraph (b) and information collected by the commissioner

232.1 of health and other relevant sources related to the uninsured in this state when developing
232.2 recommendations.

232.3 (e) The commissioner shall submit recommendations to the chairs and ranking
232.4 minority members of the legislative committees and divisions with jurisdiction over health
232.5 and human services and finance by January 15, 2014.

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

232.7 Sec. 34. **REQUEST FOR INFORMATION; EMERGENCY MEDICAL**
232.8 **ASSISTANCE.**

232.9 (a) The commissioner of human services shall issue a request for information (RFI)
232.10 to identify and develop options for a program to provide emergency medical assistance
232.11 recipients with coverage for medically necessary services not eligible for federal financial
232.12 participation. The RFI must focus on providing coverage for nonemergent services
232.13 for recipients who have two or more chronic conditions and have had two or more
232.14 hospitalizations covered by emergency medical assistance in a one-year period.

232.15 (b) The RFI must be issued by August 1, 2013, and require respondents to submit
232.16 information to the commissioner by November 1, 2013. The RFI must request information
232.17 on:

232.18 (1) services necessary to reduce emergency department and inpatient hospital use for
232.19 emergency medical assistance recipients;

232.20 (2) methods of service delivery that promote efficiency and cost-effectiveness, and
232.21 provide statewide access;

232.22 (3) funding options for the services to be covered under the program;

232.23 (4) coordination of service delivery and funding with services covered under
232.24 emergency medical assistance;

232.25 (5) options for program administration; and

232.26 (6) methods to evaluate the program, including evaluation of cost-effectiveness and
232.27 health outcomes for those emergency medical assistance recipients eligible for coverage
232.28 of additional services under the program.

232.29 (c) The commissioner shall make information submitted in response to the RFI
232.30 available on the agency Web site. The commissioner, based on the responses to the RFI,
232.31 shall submit recommendations on providing emergency medical assistance recipients
232.32 with coverage for nonemergent services, as described in paragraph (a), to the chairs and
232.33 ranking minority members of the legislative committees with jurisdiction over health and
232.34 human services policy and finance by January 15, 2014.

233.1 Sec. 35. **DENTAL ACCESS AND REIMBURSEMENT REPORT.**

233.2 Subdivision 1. Study. (a) The commissioner of human services shall study
233.3 the current oral health and dental services delivery system for state public health
233.4 care programs to improve access and ensure cost-effective delivery of services. The
233.5 commissioner shall make recommendations on modifying the delivery of services and
233.6 reimbursement methods, including modifications to the critical access dental provider
233.7 payments under Minnesota Statutes, section 256B.76, subdivision 4.

233.8 (b) The commissioner shall consult with dental providers enrolled in Minnesota
233.9 health care programs, including providers who serve substantial numbers of low-income
233.10 and uninsured patients and are currently receiving enhanced critical access dental provider
233.11 payments.

233.12 Subd. 2. Service delivery and reimbursement methods. The recommendations
233.13 must address:

233.14 (1) targeting state funding and critical access dental payments to improve access
233.15 to oral health services for individuals enrolled in Minnesota health care programs who
233.16 are not receiving timely and appropriate dental services;

233.17 (2) encouraging the use of cost-effective service delivery methods, workforce
233.18 innovations, and the delivery of preventive services, including, but not limited to, dental
233.19 sealants that will reduce dental disease and future costs of treatment;

233.20 (3) improving access in all geographic areas of the state;

233.21 (4) encouraging the use of tele-dentistry and mobile dental equipment to serve
233.22 underserved patients and communities;

233.23 (5) evaluating the use of a single administrator delivery model;

233.24 (6) compensating providers for the added costs to providers of serving low-income
233.25 and underserved patients and populations who experience the greatest oral health
233.26 disparities in terms of incidence of oral health disease and access to and utilization of
233.27 needed oral health services;

233.28 (7) encouraging coordination of oral health care with other health care services;

233.29 (8) preventing overtreatment, fraud, and abuse; and

233.30 (9) reducing administrative costs for the state and for dental providers.

233.31 Subd. 3. Report. The commissioner shall submit a report on the recommendations to
233.32 the chairs and ranking minority members of the of the legislative committees and divisions
233.33 with jurisdiction over health and human services policy and finance by December 15, 2013.

234.1 **ARTICLE 7**

234.2 **CONTINUING CARE**

234.3 Section 1. Minnesota Statutes 2012, section 144.0724, subdivision 6, is amended to read:

234.4 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete
234.5 or submit an assessment for a RUG-III or RUG-IV classification within seven days of the
234.6 time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident.
234.7 The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on
234.8 the day of admission for new admission assessments or on the day that the assessment
234.9 was due for all other assessments and continues in effect until the first day of the month
234.10 following the date of submission of the resident's assessment.

234.11 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
234.12 are equal to or greater than 1.0 percent of the total operating costs on the facility's most
234.13 recent annual statistical and cost report, a facility may apply to the commissioner of
234.14 human services for a reduction in the total penalty amount. The commissioner of human
234.15 services, in consultation with the commissioner of health, may, at the sole discretion of
234.16 the commissioner of human services, limit the penalty for residents covered by medical
234.17 assistance to 15 days.

234.18 Sec. 2. Minnesota Statutes 2012, section 144A.071, subdivision 4b, is amended to read:

234.19 Subd. 4b. **Licensed beds on layaway status.** A licensed and certified nursing
234.20 facility may lay away, upon prior written notice to the commissioner of health, licensed
234.21 and certified beds. A nursing facility may not discharge a resident in order to lay away
234.22 a bed. Notice to the commissioner shall be given 60 days prior to the effective date of
234.23 the layaway. Beds on layaway shall have the same status as voluntarily delicensed and
234.24 decertified beds and shall not be subject to license fees and license surcharge fees. In
234.25 addition, beds on layaway may be removed from layaway at any time on or after ~~one year~~
234.26 six months after the effective date of layaway in the facility of origin, with a 60-day notice
234.27 to the commissioner. A nursing facility that removes beds from layaway may not place
234.28 beds on layaway status for ~~one year~~ six months after the effective date of the removal from
234.29 layaway. The commissioner may approve the immediate removal of beds from layaway if
234.30 necessary to provide access to those nursing home beds to residents relocated from other
234.31 nursing homes due to emergency situations or closure. In the event approval is granted,
234.32 the ~~one-year~~ six-month restriction on placing beds on layaway after a removal of beds
234.33 from layaway shall not apply. Beds may remain on layaway for up to ten years. The
234.34 commissioner may approve placing and removing beds on layaway at any time during
234.35 renovation or construction related to a moratorium project approved under this section

235.1 or section 144A.073. Nursing facilities are not required to comply with any licensure or
235.2 certification requirements for beds on layaway status.

235.3 Sec. 3. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

235.4 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
235.5 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
235.6 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
235.7 9555.6265, under this chapter for a physical location that will not be the primary residence
235.8 of the license holder for the entire period of licensure. If a license is issued during this
235.9 moratorium, and the license holder changes the license holder's primary residence away
235.10 from the physical location of the foster care license, the commissioner shall revoke the
235.11 license according to section 245A.07. Exceptions to the moratorium include:

235.12 (1) foster care settings that are required to be registered under chapter 144D;

235.13 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
235.14 and determined to be needed by the commissioner under paragraph (b);

235.15 (3) new foster care licenses determined to be needed by the commissioner under
235.16 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center;
235.17 ~~or~~; restructuring of state-operated services that limits the capacity of state-operated
235.18 facilities; or, allowing movement to the community for people who no longer require the
235.19 level of care provided in state-operated facilities as provided under section 256B.092,
235.20 subdivision 13, or 256B.49, subdivision 24;

235.21 (4) new foster care licenses determined to be needed by the commissioner under
235.22 paragraph (b) for persons requiring hospital level care; or

235.23 (5) new foster care licenses determined to be needed by the commissioner for the
235.24 transition of people from personal care assistance to the home and community-based
235.25 services.

235.26 (b) The commissioner shall determine the need for newly licensed foster care homes
235.27 as defined under this subdivision. As part of the determination, the commissioner shall
235.28 consider the availability of foster care capacity in the area in which the licensee seeks to
235.29 operate, and the recommendation of the local county board. The determination by the
235.30 commissioner must be final. A determination of need is not required for a change in
235.31 ownership at the same address.

235.32 ~~(c) The commissioner shall study the effects of the license moratorium under this~~
235.33 ~~subdivision and shall report back to the legislature by January 15, 2011. This study shall~~
235.34 ~~include, but is not limited to the following:~~

236.1 ~~(1) the overall capacity and utilization of foster care beds where the physical location~~
236.2 ~~is not the primary residence of the license holder prior to and after implementation~~
236.3 ~~of the moratorium;~~

236.4 ~~(2) the overall capacity and utilization of foster care beds where the physical~~
236.5 ~~location is the primary residence of the license holder prior to and after implementation~~
236.6 ~~of the moratorium; and~~

236.7 ~~(3) the number of licensed and occupied ICF/MR beds prior to and after~~
236.8 ~~implementation of the moratorium.~~

236.9 ~~(d)~~ (c) When a foster care recipient moves out of a foster home that is not the primary
236.10 residence of the license holder according to section 256B.49, subdivision 15, paragraph
236.11 (f), the county shall immediately inform the Department of Human Services Licensing
236.12 Division. The department shall decrease the statewide licensed capacity for foster care
236.13 settings where the physical location is not the primary residence of the license holder, if
236.14 the voluntary changes described in paragraph ~~(f)~~ (e) are not sufficient to meet the savings
236.15 required by reductions in licensed bed capacity under Laws 2011, First Special Session
236.16 chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term
236.17 care residential services capacity within budgetary limits. Implementation of the statewide
236.18 licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense
236.19 up to 128 beds by June 30, 2014, using the needs determination process. Under this
236.20 paragraph, the commissioner has the authority to reduce unused licensed capacity of a
236.21 current foster care program to accomplish the consolidation or closure of settings. Under
236.22 this paragraph, the commissioner has the authority to manage statewide capacity, including
236.23 adjusting the capacity available to each county and adjusting statewide available capacity,
236.24 to meet the statewide needs identified through the process in paragraph (e). A decreased
236.25 licensed capacity according to this paragraph is not subject to appeal under this chapter.

236.26 ~~(e)~~ (d) Residential settings that would otherwise be subject to the decreased license
236.27 capacity established in paragraph ~~(d)~~ (c) shall be exempt under the following circumstances:

236.28 (1) until August 1, 2013, the license holder's beds occupied by residents whose
236.29 primary diagnosis is mental illness and the license holder is:

236.30 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
236.31 health services (ARMHS) as defined in section 256B.0623;

236.32 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
236.33 9520.0870;

236.34 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
236.35 9520.0870; or

237.1 (iv) a provider of intensive residential treatment services (IRTS) licensed under
237.2 Minnesota Rules, parts 9520.0500 to 9520.0670; or

237.3 (2) the license holder's beds occupied by residents whose primary diagnosis is
237.4 mental illness and the license holder is certified under the requirements in subdivision 6a.

237.5 ~~(f)~~ (e) A resource need determination process, managed at the state level, using the
237.6 available reports required by section 144A.351, and other data and information shall
237.7 be used to determine where the reduced capacity required under paragraph ~~(d)~~ (c) will
237.8 be implemented. The commissioner shall consult with the stakeholders described in
237.9 section 144A.351, and employ a variety of methods to improve the state's capacity to
237.10 meet long-term care service needs within budgetary limits, including seeking proposals
237.11 from service providers or lead agencies to change service type, capacity, or location to
237.12 improve services, increase the independence of residents, and better meet needs identified
237.13 by the long-term care services reports and statewide data and information. By February
237.14 ~~1 of each~~, 2013, and August 1, 2014, and each following year, the commissioner shall
237.15 provide information and data on the overall capacity of licensed long-term care services,
237.16 actions taken under this subdivision to manage statewide long-term care services and
237.17 supports resources, and any recommendations for change to the legislative committees
237.18 with jurisdiction over health and human services budget.

237.19 ~~(g)~~ (f) At the time of application and reapplication for licensure, the applicant and the
237.20 license holder that are subject to the moratorium or an exclusion established in paragraph
237.21 (a) are required to inform the commissioner whether the physical location where the foster
237.22 care will be provided is or will be the primary residence of the license holder for the entire
237.23 period of licensure. If the primary residence of the applicant or license holder changes, the
237.24 applicant or license holder must notify the commissioner immediately. The commissioner
237.25 shall print on the foster care license certificate whether or not the physical location is the
237.26 primary residence of the license holder.

237.27 ~~(h)~~ (g) License holders of foster care homes identified under paragraph ~~(g)~~ (f) that
237.28 are not the primary residence of the license holder and that also provide services in the
237.29 foster care home that are covered by a federally approved home and community-based
237.30 services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must
237.31 inform the human services licensing division that the license holder provides or intends to
237.32 provide these waiver-funded services. These license holders must be considered registered
237.33 under section 256B.092, subdivision 11, paragraph (c), and this registration status must
237.34 be identified on their license certificates.

238.1 Sec. 4. Minnesota Statutes 2012, section 252.291, is amended by adding a subdivision
238.2 to read:

238.3 Subd. 2b. Nicollet County facility project. The commissioner of health shall
238.4 certify one additional bed in an intermediate care facility for persons with developmental
238.5 disabilities in Nicollet County.

238.6 Sec. 5. Minnesota Statutes 2012, section 256.9657, subdivision 3a, is amended to read:

238.7 Subd. 3a. **ICF/MR ICF/DD license surcharge.** (a) Effective July 1, 2003, each
238.8 non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay
238.9 to the commissioner an annual surcharge according to the schedule in subdivision 4,
238.10 paragraph (d). The annual surcharge shall be \$1,040 per licensed bed. If the number of
238.11 licensed beds is reduced, the surcharge shall be based on the number of remaining licensed
238.12 beds the second month following the receipt of timely notice by the commissioner of
238.13 human services that beds have been delicensed. The facility must notify the commissioner
238.14 of health in writing when beds are delicensed. The commissioner of health must notify
238.15 the commissioner of human services within ten working days after receiving written
238.16 notification. If the notification is received by the commissioner of human services by
238.17 the 15th of the month, the invoice for the second following month must be reduced to
238.18 recognize the delicensing of beds. The commissioner may reduce, and may subsequently
238.19 restore, the surcharge under this subdivision based on the commissioner's determination of
238.20 a permissible surcharge.

238.21 (b) Effective July 1, 2013, the surcharge under paragraph (a) is increased to \$3,679
238.22 per licensed bed.

238.23 **EFFECTIVE DATE.** This section is effective July 1, 2013.

238.24 Sec. 6. Minnesota Statutes 2012, section 256B.0915, subdivision 3a, is amended to read:

238.25 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
238.26 waived services to an individual elderly waiver client except for individuals described in
238.27 ~~paragraph~~ paragraphs (b) and (d) shall be the weighted average monthly nursing facility
238.28 rate of the case mix resident class to which the elderly waiver client would be assigned
238.29 under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance
238.30 needs allowance as described in subdivision 1d, paragraph (a), until the first day of the
238.31 state fiscal year in which the resident assessment system as described in section 256B.438
238.32 for nursing home rate determination is implemented. Effective on the first day of the state
238.33 fiscal year in which the resident assessment system as described in section 256B.438 for
238.34 nursing home rate determination is implemented and the first day of each subsequent state

239.1 fiscal year, the monthly limit for the cost of waived services to an individual elderly
239.2 waiver client shall be the rate of the case mix resident class to which the waiver client
239.3 would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on
239.4 the last day of the previous state fiscal year, adjusted by any legislatively adopted home
239.5 and community-based services percentage rate adjustment.

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

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

239.9 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating
239.10 when the dependency score in eating is three or greater as determined by an assessment
239.11 performed under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011,
239.12 for all new participants enrolled in the program on or after July 1, 2011. This monthly
239.13 limit shall be applied to all other participants who meet this criteria at reassessment. This
239.14 monthly limit shall be increased annually as described in paragraph (a).

239.15 (c) If extended medical supplies and equipment or environmental modifications are
239.16 or will be purchased for an elderly waiver client, the costs may be prorated for up to
239.17 12 consecutive months beginning with the month of purchase. If the monthly cost of a
239.18 recipient's waived services exceeds the monthly limit established in paragraph (a) or
239.19 (b), the annual cost of all waived services shall be determined. In this event, the annual
239.20 cost of all waived services shall not exceed 12 times the monthly limit of waived
239.21 services as described in paragraph (a) or (b).

239.22 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including
239.23 any necessary home care services described in section 256B.0651, subdivision 2, for
239.24 individuals who meet the criteria as ventilator-dependent given in section 256B.0651,
239.25 subdivision 1, paragraph (g), shall be the average of the monthly medical assistance
239.26 amount established for home care services as described in section 256B.0652, subdivision
239.27 7, and the annual average contracted amount established by the commissioner for nursing
239.28 facility services for ventilator-dependent individuals. This monthly limit shall be increased
239.29 annually as described in paragraph (a).

239.30 Sec. 7. Minnesota Statutes 2012, section 256B.0915, is amended by adding a
239.31 subdivision to read:

239.32 Subd. 3j. **Individual community living support.** Upon federal approval, there
239.33 is established a new service called individual community living support (ICLS) that is
239.34 available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor
239.35 have any interest in the recipient's housing. ICLS must be delivered in a single-family

240.1 home or apartment where the service recipient or their family owns or rents, as
240.2 demonstrated by a lease agreement, and maintains control over the individual unit. Case
240.3 managers or care coordinators must develop individual ICLS plans in consultation with
240.4 the client using a tool developed by the commissioner. The commissioner shall establish
240.5 payment rates and mechanisms to align payments with the type and amount of service
240.6 provided, assure statewide uniformity for payment rates, and assure cost-effectiveness.
240.7 Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and
240.8 Human Services to avoid conflict with provider regulatory standards pursuant to section
240.9 144A.43 and chapter 245D.

240.10 Sec. 8. Minnesota Statutes 2012, section 256B.0916, is amended by adding a
240.11 subdivision to read:

240.12 Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending
240.13 in excess of the allocation made by the commissioner. In the event a county or tribal
240.14 agency spends in excess of the allocation made by the commissioner for a given allocation
240.15 period, they must submit a corrective action plan to the commissioner. The plan must state
240.16 the actions the agency will take to correct their overspending for the year following the
240.17 period when the overspending occurred. Failure to correct overspending shall result in
240.18 recoupment of spending in excess of the allocation. Nothing in this subdivision shall be
240.19 construed as reducing the county's responsibility to offer and make available feasible
240.20 home and community-based options to eligible waiver recipients within the resources
240.21 allocated to them for that purpose.

240.22 Sec. 9. Minnesota Statutes 2012, section 256B.092, subdivision 7, is amended to read:

240.23 Subd. 7. **Screening teams.** (a) For persons with developmental disabilities, screening
240.24 teams shall be established which shall evaluate the need for the level of care provided
240.25 by residential-based habilitation services, residential services, training and habilitation
240.26 services, and nursing facility services. The evaluation shall address whether home and
240.27 community-based services are appropriate for persons who are at risk of placement in an
240.28 intermediate care facility for persons with developmental disabilities, or for whom there is
240.29 reasonable indication that they might require this level of care. The screening team shall
240.30 make an evaluation of need within 60 working days of a request for service by a person
240.31 with a developmental disability, and within five working days of an emergency admission
240.32 of a person to an intermediate care facility for persons with developmental disabilities.

240.33 (b) The screening team shall consist of the case manager for persons with
240.34 developmental disabilities, the person, the person's legal guardian or conservator, or the

241.1 parent if the person is a minor, and a qualified developmental disability professional, as
241.2 defined in Code of Federal Regulations, title 42, section 483.430, as amended through
241.3 June 3, 1988. The case manager may also act as the qualified developmental disability
241.4 professional if the case manager meets the federal definition.

241.5 (c) County social service agencies may contract with a public or private agency
241.6 or individual who is not a service provider for the person for the public guardianship
241.7 representation required by the screening or individual service planning process. The
241.8 contract shall be limited to public guardianship representation for the screening and
241.9 individual service planning activities. The contract shall require compliance with the
241.10 commissioner's instructions and may be for paid or voluntary services.

241.11 (d) For persons determined to have overriding health care needs and are
241.12 seeking admission to a nursing facility or an ICF/MR, or seeking access to home and
241.13 community-based waived services, a registered nurse must be designated as either the
241.14 case manager or the qualified developmental disability professional.

241.15 (e) For persons under the jurisdiction of a correctional agency, the case manager
241.16 must consult with the corrections administrator regarding additional health, safety, and
241.17 supervision needs.

241.18 (f) The case manager, with the concurrence of the person, the person's legal guardian
241.19 or conservator, or the parent if the person is a minor, may invite other individuals to
241.20 attend meetings of the screening team. With the permission of the person being screened
241.21 or the person's designated legal representative, the person's current provider of services
241.22 may submit a written report outlining their recommendations regarding the person's care
241.23 needs prepared by a direct service employee with at least 20 hours of service to that client.
241.24 The screening team must notify the provider of the date by which this information is to
241.25 be submitted. This information must be provided to the screening team and the person
241.26 or the person's legal representative and must be considered prior to the finalization of
241.27 the screening.

241.28 (g) Upon federal approval, if during an assessment or reassessment the recipient
241.29 is determined to be able to have the recipient's needs met through alternative services
241.30 in a less restrictive setting, the case manager shall help the recipient develop a plan to
241.31 transition to an appropriate less restrictive setting.

241.32 ~~(g)~~ (h) No member of the screening team shall have any direct or indirect service
241.33 provider interest in the case.

241.34 ~~(h)~~ (i) Nothing in this section shall be construed as requiring the screening team
241.35 meeting to be separate from the service planning meeting.

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

242.1 Sec. 10. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

242.2 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
242.3 established a new service called residential support that is available on the community
242.4 alternative care, community alternatives for disabled individuals, developmental
242.5 disabilities, and brain injury waivers. Existing waiver service descriptions must be
242.6 modified to the extent necessary to ensure there is no duplication between other services.
242.7 Residential support services must be provided by vendors licensed as a community
242.8 residential setting as defined in section 245A.11, subdivision 8.

242.9 (b) Residential support services must meet the following criteria:

242.10 (1) providers of residential support services must own or control the residential site;

242.11 (2) the residential site must not be the primary residence of the license holder;

242.12 (3) the residential site must have a designated program supervisor responsible for
242.13 program oversight, development, and implementation of policies and procedures;

242.14 (4) the provider of residential support services must provide supervision, training,
242.15 and assistance as described in the person's coordinated service and support plan; and

242.16 (5) the provider of residential support services must meet the requirements of
242.17 licensure and additional requirements of the person's coordinated service and support plan.

242.18 (c) Providers of residential support services that meet the definition in paragraph

242.19 (a) must be registered using a process determined by the commissioner beginning July

242.20 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts

242.21 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts

242.22 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision

242.23 7, paragraph ~~(g)~~ (f), are considered registered under this section.

242.24 Sec. 11. Minnesota Statutes 2012, section 256B.092, subdivision 12, is amended to read:

242.25 Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall

242.26 establish statewide priorities for individuals on the waiting list for developmental

242.27 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must

242.28 include, but are not limited to, individuals who continue to have a need for waiver services

242.29 after they have maximized the use of state plan services and other funding resources,

242.30 including natural supports, prior to accessing waiver services, and who meet at least one

242.31 of the following criteria:

242.32 (1) no longer require the intensity of services provided where they are currently

242.33 living; or

242.34 (2) make a request to move from an institutional setting.

243.1 (b) After the priorities in paragraph (a) are met, priority must also be given to
243.2 individuals who meet at least one of the following criteria:

243.3 (1) have unstable living situations due to the age, incapacity, or sudden loss of
243.4 the primary caregivers;

243.5 (2) are moving from an institution due to bed closures;

243.6 (3) experience a sudden closure of their current living arrangement;

243.7 (4) require protection from confirmed abuse, neglect, or exploitation;

243.8 (5) experience a sudden change in need that can no longer be met through state plan
243.9 services or other funding resources alone; or

243.10 (6) meet other priorities established by the department.

243.11 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
243.12 consideration the number of individuals waiting who meet statewide priorities and the
243.13 lead agencies' current use of waiver funds and existing service options. The commissioner
243.14 has the authority to transfer funds between counties, groups of counties, and tribes to
243.15 accommodate statewide priorities and resource needs while accounting for a necessary
243.16 base level reserve amount for each county, group of counties, and tribe.

243.17 ~~(e) The commissioner shall evaluate the impact of the use of statewide priorities and~~
243.18 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
243.19 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
243.20 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

243.21 Sec. 12. Minnesota Statutes 2012, section 256B.092, is amended by adding a
243.22 subdivision to read:

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

243.31 (1) conduct a functional assessment of the crisis incident as defined in section
243.32 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
243.33 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
243.34 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

244.12 Sec. 13. **[256B.0922] ESSENTIAL COMMUNITY SUPPORTS.**

244.13 Subdivision 1. **Essential community supports.** (a) The purpose of the essential
244.14 community supports program is to provide targeted services to persons age 65 and older
244.15 who need essential community support, but whose needs do not meet the level of care
244.16 required for nursing facility placement under section 144.0724, subdivision 11.

244.17 (b) Essential community supports are available not to exceed \$400 per person per
244.18 month. Essential community supports may be used as authorized within an authorization
244.19 period not to exceed 12 months. Services must be available to a person who:

244.20 (1) is age 65 or older;

244.21 (2) is not eligible for medical assistance;

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

244.24 (4) meets the financial eligibility criteria for the alternative care program under
244.25 section 256B.0913, subdivision 4;

244.26 (5) has a community support plan; and

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

244.31 (i) caregiver support;

244.32 (ii) homemaker support;

244.33 (iii) chores;

244.34 (iv) a personal emergency response device or system;

244.35 (v) home-delivered meals; or

245.1 (vi) community living assistance as defined by the commissioner.

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

245.5 (d) A person who has been determined to be eligible for essential community
245.6 supports must be reassessed at least annually and continue to meet the criteria in paragraph
245.7 (b) to remain eligible for essential community supports.

245.8 (e) The commissioner is authorized to use federal matching funds for essential
245.9 community supports as necessary and to meet demand for essential community supports
245.10 as outlined in subdivision 2, and that amount of federal funds is appropriated to the
245.11 commissioner for this purpose.

245.12 Subd. 2. **Essential community supports for people in transition.** (a) Essential
245.13 community supports under subdivision 1 are also available to an individual who:

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

245.18 (2) meets one of the following criteria:

245.19 (i) due to the implementation of the revised nursing facility level of care, loses
245.20 eligibility for continuing medical assistance payment of nursing facility services at the
245.21 first reassessment under section 144.0724, subdivision 11, paragraph (b), that occurs on or
245.22 after the effective date of the revised nursing facility level of care criteria under section
245.23 144.0724, subdivision 11; or

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

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

245.31 (4) has an assessed need for one or more of the supportive services offered under
245.32 essential community supports under subdivision 1, paragraph (b), clause (6).

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

246.1 (b) Additional onetime case management is available for participants under
246.2 paragraph (a), not to exceed \$600 per person to be used within one authorization period
246.3 not to exceed 12 months. This service is provided in addition to the essential community
246.4 supports benefit described under subdivision 1, paragraph (b).

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

246.6 Sec. 14. [256B.0949] **AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.**

246.7 Subdivision 1. **Purpose.** This section creates a new benefit to provide early
246.8 intensive intervention to a child with an autism spectrum disorder diagnosis. This benefit
246.9 must provide coverage for diagnosis, multidisciplinary assessment, ongoing progress
246.10 evaluation, and medically necessary treatment of autism spectrum disorder.

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

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

246.15 (c) "Child" means a person under the age of 18.

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

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

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

246.26 (g) "Mental health professional" has the meaning given in section 245.4871,
246.27 subdivision 27, clauses (1) to (6).

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

246.30 (1) has an autism spectrum disorder diagnosis;

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

246.33 (3) meets the criteria for medically necessary autism early intensive intervention
246.34 services.

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

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

247.3 (2) be completed by both a licensed physician or advanced practice registered nurse
247.4 and a mental health professional.

247.5 (b) Additional diagnostic assessment information may be considered including from
247.6 special education evaluations and licensed school personnel, and from professionals
247.7 licensed in the fields of medicine, speech and language, psychology, occupational therapy,
247.8 and physical therapy.

247.9 (c) If the commissioner determines there are access problems or delays in diagnosis
247.10 for a geographic area due to the lack of qualified professionals, the commissioner shall
247.11 waive the requirement in paragraph (a), clause (2), for two professionals and allow a
247.12 diagnosis to be made by one professional for that geographic area. This exception must be
247.13 limited to a specific period of time until, with stakeholder input as described in subdivision
247.14 8, there is a determination of an adequate number of professionals available to require two
247.15 professionals for each diagnosis.

247.16 Subd. 5. **Diagnostic assessment.** The following information and assessments must
247.17 be performed, reviewed, and relied upon for the eligibility determination, treatment and
247.18 services recommendations, and treatment plan development for the child:

247.19 (1) an assessment of the child's developmental skills, functional behavior, needs, and
247.20 capacities based on direct observation of the child which must be administered by a licensed
247.21 mental health professional and may also include observations from family members,
247.22 school personnel, child care providers, or other caregivers, as well as any medical or
247.23 assessment information from other licensed professionals such as the child's physician,
247.24 rehabilitation therapists, licensed school personnel, or mental health professionals; and
247.25 (2) an assessment of parental or caregiver capacity to participate in therapy including
247.26 the type and level of parental or caregiver involvement and training recommended.

247.27 Subd. 6. **Treatment plan.** (a) Each child's treatment plan must be:

247.28 (1) based on the diagnostic assessment information specified in subdivisions 4 and 5;
247.29 (2) coordinated with medically necessary occupational, physical, and speech and
247.30 language therapies, special education, and other services the child and family are receiving;
247.31 (3) family-centered;
247.32 (4) culturally sensitive; and
247.33 (5) individualized based on the child's developmental status and the child's and
247.34 family's identified needs.

247.35 (b) The treatment plan must specify the:

- 248.1 (1) child's goals which are developmentally appropriate, functional, and
248.2 generalizable;
- 248.3 (2) treatment modality;
248.4 (3) treatment intensity;
248.5 (4) setting; and
248.6 (5) level and type of parental or caregiver involvement.
- 248.7 (c) The treatment must be supervised by a professional with expertise and training in
248.8 autism and child development who is a licensed physician, advanced practice registered
248.9 nurse, or mental health professional.
- 248.10 (d) The treatment plan must be submitted to the commissioner for approval in a
248.11 manner determined by the commissioner for this purpose.
- 248.12 (e) Services authorized must be consistent with the child's approved treatment plan.
248.13 Services included in the treatment plan must meet all applicable requirements for
248.14 medical necessity and coverage.
- 248.15 Subd. 7. **Ongoing eligibility.** (a) An independent progress evaluation conducted
248.16 by a licensed mental health professional with expertise and training in autism spectrum
248.17 disorder and child development must be completed after each six months of treatment,
248.18 or more frequently as determined by the commissioner, to determine if progress is being
248.19 made toward achieving generalizable goals and meeting functional goals contained in
248.20 the treatment plan.
- 248.21 (b) The progress evaluation must include:
- 248.22 (1) the treating provider's report;
248.23 (2) parental or caregiver input;
248.24 (3) an independent observation of the child which can be performed by the child's
248.25 licensed special education staff;
248.26 (4) any treatment plan modifications; and
248.27 (5) recommendations for continued treatment services.
- 248.28 (c) Progress evaluations must be submitted to the commissioner in a manner
248.29 determined by the commissioner for this purpose.
- 248.30 (d) A child who continues to achieve generalizable goals and treatment goals as
248.31 specified in the treatment plan is eligible to continue receiving this benefit.
- 248.32 (e) A child's treatment shall continue during the progress evaluation using the
248.33 process determined under subdivision 8, clause (8). Treatment may continue during an
248.34 appeal pursuant to section 256.045.
- 248.35 Subd. 8. **Refining the benefit with stakeholders.** The commissioner must develop
248.36 the implementation details of the benefit in consultation with stakeholders and consider

249.1 recommendations from the Health Services Advisory Council, the Department of Human
249.2 Services Autism Spectrum Disorder Advisory Council, the Legislative Autism Spectrum
249.3 Disorder Task Force, and the Interagency Task Force of the Departments of Health,
249.4 Education, and Human Services. The commissioner must release these details for a 30-day
249.5 public comment period prior to submission to the federal government for approval. The
249.6 implementation details must include, but are not limited to, the following components:
249.7 (1) a definition of the qualifications, standards, and roles of the treatment team,
249.8 including recommendations after stakeholder consultation on whether board-certified
249.9 behavior analysts and other types of professionals trained in autism spectrum disorder and
249.10 child development should be added as mental health or other professionals for treatment
249.11 supervision or other functions under medical assistance;
249.12 (2) development of initial, uniform parameters for comprehensive multidisciplinary
249.13 diagnostic assessment information and progress evaluation standards;
249.14 (3) the design of an effective and consistent process for assessing parent and
249.15 caregiver capacity to participate in the child's early intervention treatment and methods of
249.16 involving the parents and caregivers in the treatment of the child;
249.17 (4) formulation of a collaborative process in which professionals have opportunities
249.18 to collectively inform a comprehensive, multidisciplinary diagnostic assessment and
249.19 progress evaluation processes and standards to support quality improvement of early
249.20 intensive intervention services;
249.21 (5) coordination of this benefit and its interaction with other services provided by the
249.22 Departments of Human Services, Health, and Education;
249.23 (6) evaluation, on an ongoing basis, of research regarding the program and treatment
249.24 modalities provided to children under this benefit;
249.25 (7) determination of the availability of licensed physicians, nurse practitioners,
249.26 and mental health professionals with expertise and training in autism spectrum disorder
249.27 throughout the state to assess whether there are sufficient professionals to require
249.28 involvement of both a physician or nurse practitioner and a mental health professional to
249.29 provide access and prevent delay in the diagnosis and treatment of young children, so as to
249.30 implement subdivision 4, and to ensure treatment is effective, timely, and accessible; and
249.31 (8) development of the process for the progress evaluation that will be used to
249.32 determine the ongoing eligibility, including necessary documentation, timelines, and
249.33 responsibilities of all parties.
249.34 Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered
249.35 treatment options as needed based on outcome data and other evidence.

250.1 (b) Before the changes become effective, the commissioner must provide public
250.2 notice of the changes, the reasons for the change, and a 30-day public comment period
250.3 to those who request notice through an electronic list accessible to the public on the
250.4 department's Web site.

250.5 Subd. 10. **Coordination between agencies.** The commissioners of human services
250.6 and education must develop the capacity to coordinate services and information including
250.7 diagnostic, functional, developmental, medical, and educational assessments; service
250.8 delivery; and progress evaluations across health and education sectors.

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

250.15 **EFFECTIVE DATE.** Subdivisions 1 to 7 and 9, are effective upon federal approval
250.16 consistent with subdivision 11, but no earlier than March 1, 2014. Subdivisions 8, 10,
250.17 and 11 are effective July 1, 2013.

250.18 Sec. 15. Minnesota Statutes 2012, section 256B.095, is amended to read:

250.19 **256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.**

250.20 (a) Effective July 1, 1998, a quality assurance system for persons with developmental
250.21 disabilities, which includes an alternative quality assurance licensing system for programs,
250.22 is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice,
250.23 Steele, Wabasha, and Winona Counties for the purpose of improving the quality of
250.24 services provided to persons with developmental disabilities. A county, at its option, may
250.25 choose to have all programs for persons with developmental disabilities located within
250.26 the county licensed under chapter 245A using standards determined under the alternative
250.27 quality assurance licensing system or may continue regulation of these programs under the
250.28 licensing system operated by the commissioner. ~~The project expires on June 30, 2014.~~

250.29 (b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to
250.30 participate in the quality assurance system established under paragraph (a). The
250.31 commission established under section 256B.0951 may, at its option, allow additional
250.32 counties to participate in the system.

250.33 (c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a)
250.34 may establish a quality assurance system under this section. A new system established

251.1 under this section shall have the same rights and duties as the system established
251.2 under paragraph (a). A new system shall be governed by a commission under section
251.3 256B.0951. The commissioner shall appoint the initial commission members based
251.4 on recommendations from advocates, families, service providers, and counties in the
251.5 geographic area included in the new system. Counties that choose to participate in a
251.6 new system shall have the duties assigned under section 256B.0952. The new system
251.7 shall establish a quality assurance process under section 256B.0953. The provisions of
251.8 section 256B.0954 shall apply to a new system established under this paragraph. The
251.9 commissioner shall delegate authority to a new system established under this paragraph
251.10 according to section 256B.0955.

251.11 (d) Effective July 1, 2007, the quality assurance system may be expanded to include
251.12 programs for persons with disabilities and older adults.

251.13 (e) Effective July 1, 2013, a provider of service located in a county listed in
251.14 paragraph (a) that is a non-opted-in county may opt in to the quality assurance system
251.15 provided the county where services are provided indicates its agreement with a county
251.16 with a delegation agreement with the Department of Human Services.

251.17 **EFFECTIVE DATE.** This section is effective July 1, 2013.

251.18 Sec. 16. Minnesota Statutes 2012, section 256B.0951, subdivision 1, is amended to read:

251.19 Subdivision 1. **Membership.** The Quality Assurance Commission is established.
251.20 The commission consists of at least 14 but not more than 21 members as follows: at
251.21 least three but not more than five members representing advocacy organizations; at
251.22 least three but not more than five members representing consumers, families, and their
251.23 legal representatives; at least three but not more than five members representing service
251.24 providers; at least three but not more than five members representing counties; and the
251.25 commissioner of human services or the commissioner's designee. The first commission
251.26 shall establish membership guidelines for the transition and recruitment of membership for
251.27 the commission's ongoing existence. Members of the commission who do not receive a
251.28 salary or wages from an employer for time spent on commission duties may receive a per
251.29 diem payment when performing commission duties and functions. All members may be
251.30 reimbursed for expenses related to commission activities. ~~Notwithstanding the provisions~~
251.31 ~~of section 15.059, subdivision 5, the commission expires on June 30, 2014.~~

251.32 Sec. 17. Minnesota Statutes 2012, section 256B.0951, subdivision 4, is amended to read:

251.33 Subd. 4. **Commission's authority to recommend variances of licensing**
251.34 **standards.** The commission may recommend to the commissioners of human services

252.1 and health variances from the standards governing licensure of programs for persons with
252.2 developmental disabilities in order to improve the quality of services by implementing
252.3 an alternative developmental disabilities licensing system if the commission determines
252.4 that the alternative licensing system does not adversely affect the health or safety of
252.5 persons being served by the licensed program nor compromise the qualifications of staff
252.6 to provide services.

252.7 Sec. 18. Minnesota Statutes 2012, section 256B.0952, subdivision 1, is amended to read:

252.8 Subdivision 1. **Notification.** Counties or providers shall give notice to the
252.9 commission and commissioners of human services and health of intent to join the
252.10 alternative quality assurance licensing system. A county or provider choosing to participate
252.11 in the alternative quality assurance licensing system commits to participate for three years.

252.12 Sec. 19. Minnesota Statutes 2012, section 256B.0952, subdivision 5, is amended to read:

252.13 Subd. 5. **Quality assurance teams.** Quality assurance teams shall be comprised
252.14 of county staff; providers; consumers, families, and their legal representatives; members
252.15 of advocacy organizations; and other involved community members. Team members
252.16 must satisfactorily complete the training program approved by the commission and must
252.17 demonstrate performance-based competency. Team members are not considered to be
252.18 county employees for purposes of workers' compensation, unemployment insurance, or
252.19 state retirement laws solely on the basis of participation on a quality assurance team. ~~The~~
252.20 ~~county may pay~~ A per diem may be paid to team members for time spent on alternative
252.21 quality assurance process matters. All team members may be reimbursed for expenses
252.22 related to their participation in the alternative process.

252.23 Sec. 20. Minnesota Statutes 2012, section 256B.0955, is amended to read:

252.24 **256B.0955 DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.**

252.25 (a) Effective July 1, 1998, the commissioner of human services shall delegate
252.26 authority to perform licensing functions and activities, in accordance with section
252.27 245A.16, to counties participating in the alternative quality assurance licensing system.
252.28 The commissioner shall not license or reimburse a facility, program, or service for persons
252.29 with ~~developmental~~ disabilities in a county that participates in the alternative quality
252.30 assurance licensing system if the commissioner has received from the appropriate county
252.31 notification that the facility, program, or service has been reviewed by a quality assurance
252.32 team and has failed to qualify for licensure.

253.1 (b) The commissioner may conduct random licensing inspections based on outcomes
253.2 adopted under section 256B.0951 at facilities, programs, and services governed by the
253.3 alternative quality assurance licensing system. The role of such random inspections shall
253.4 be to verify that the alternative quality assurance licensing system protects the safety
253.5 and well-being of consumers and maintains the availability of high-quality services for
253.6 persons with developmental disabilities.

253.7 **EFFECTIVE DATE.** This section is effective July 1, 2013.

253.8 Sec. 21. Minnesota Statutes 2012, section 256B.097, subdivision 1, is amended to read:

253.9 Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to
253.10 Minnesotans with disabilities and to meet the requirements of the federally approved home
253.11 and community-based waivers under section 1915c of the Social Security Act, a State
253.12 Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving
253.13 disability services is enacted. This system is a partnership between the Department of
253.14 Human Services and the State Quality Council established under subdivision 3.

253.15 (b) This system is a result of the recommendations from the Department of Human
253.16 Services' licensing and alternative quality assurance study mandated under Laws 2005,
253.17 First Special Session chapter 4, article 7, section 57, and presented to the legislature
253.18 in February 2007.

253.19 (c) The disability services eligible under this section include:

253.20 (1) the home and community-based services waiver programs for persons with
253.21 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
253.22 including brain injuries and services for those who qualify for nursing facility level of care
253.23 or hospital facility level of care and any other services licensed under chapter 245D;

253.24 (2) home care services under section 256B.0651;

253.25 (3) family support grants under section 252.32;

253.26 (4) consumer support grants under section 256.476;

253.27 (5) semi-independent living services under section 252.275; and

253.28 (6) services provided through an intermediate care facility for the developmentally
253.29 disabled.

253.30 (d) For purposes of this section, the following definitions apply:

253.31 (1) "commissioner" means the commissioner of human services;

253.32 (2) "council" means the State Quality Council under subdivision 3;

253.33 (3) "Quality Assurance Commission" means the commission under section
253.34 256B.0951; and

254.1 (4) "system" means the State Quality Assurance, Quality Improvement and
254.2 Licensing System under this section.

254.3 Sec. 22. Minnesota Statutes 2012, section 256B.097, subdivision 3, is amended to read:

254.4 Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality
254.5 Council which must define regional quality councils, and carry out a community-based,
254.6 person-directed quality review component, and a comprehensive system for effective
254.7 incident reporting, investigation, analysis, and follow-up.

254.8 (b) By August 1, 2011, the commissioner of human services shall appoint the
254.9 members of the initial State Quality Council. Members shall include representatives
254.10 from the following groups:

254.11 (1) disability service recipients and their family members;

254.12 (2) during the first ~~two~~ four years of the State Quality Council, there must be at least
254.13 three members from the Region 10 stakeholders. As regional quality councils are formed
254.14 under subdivision 4, each regional quality council shall appoint one member;

254.15 (3) disability service providers;

254.16 (4) disability advocacy groups; and

254.17 (5) county human services agencies and staff from the Department of Human
254.18 Services and Ombudsman for Mental Health and Developmental Disabilities.

254.19 (c) Members of the council who do not receive a salary or wages from an employer
254.20 for time spent on council duties may receive a per diem payment when performing council
254.21 duties and functions.

254.22 (d) The State Quality Council shall:

254.23 (1) assist the Department of Human Services in fulfilling federally mandated
254.24 obligations by monitoring disability service quality and quality assurance and
254.25 improvement practices in Minnesota;

254.26 (2) establish state quality improvement priorities with methods for achieving results
254.27 and provide an annual report to the legislative committees with jurisdiction over policy
254.28 and funding of disability services on the outcomes, improvement priorities, and activities
254.29 undertaken by the commission during the previous state fiscal year;

254.30 (3) identify issues pertaining to financial and personal risk that impede Minnesotans
254.31 with disabilities from optimizing choice of community-based services; and

254.32 (4) recommend to the chairs and ranking minority members of the legislative
254.33 committees with jurisdiction over human services and civil law by January 15, ~~2013~~
254.34 2014, statutory and rule changes related to the findings under clause (3) that promote

255.1 individualized service and housing choices balanced with appropriate individualized
255.2 protection.

255.3 (e) The State Quality Council, in partnership with the commissioner, shall:

255.4 (1) approve and direct implementation of the community-based, person-directed
255.5 system established in this section;

255.6 (2) recommend an appropriate method of funding this system, and determine the
255.7 feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

255.8 (3) approve measurable outcomes in the areas of health and safety, consumer
255.9 evaluation, education and training, providers, and systems;

255.10 (4) establish variable licensure periods not to exceed three years based on outcomes
255.11 achieved; and

255.12 (5) in cooperation with the Quality Assurance Commission, design a transition plan
255.13 for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

255.14 (f) The State Quality Council shall notify the commissioner of human services that a
255.15 facility, program, or service has been reviewed by quality assurance team members under
255.16 subdivision 4, paragraph (b), clause (13), and qualifies for a license.

255.17 (g) The State Quality Council, in partnership with the commissioner, shall establish
255.18 an ongoing review process for the system. The review shall take into account the
255.19 comprehensive nature of the system which is designed to evaluate the broad spectrum of
255.20 licensed and unlicensed entities that provide services to persons with disabilities. The
255.21 review shall address efficiencies and effectiveness of the system.

255.22 (h) The State Quality Council may recommend to the commissioner certain
255.23 variances from the standards governing licensure of programs for persons with disabilities
255.24 in order to improve the quality of services so long as the recommended variances do
255.25 not adversely affect the health or safety of persons being served or compromise the
255.26 qualifications of staff to provide services.

255.27 (i) The safety standards, rights, or procedural protections referenced under
255.28 subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
255.29 recommendations to the commissioner or to the legislature in the report required under
255.30 paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
255.31 procedural protections referenced under subdivision 2, paragraph (c).

255.32 (j) The State Quality Council may hire staff to perform the duties assigned in this
255.33 subdivision.

255.34 Sec. 23. Minnesota Statutes 2012, section 256B.431, subdivision 44, is amended to read:

256.1 Subd. 44. **Property rate increase increases for a facility in Bloomington effective**
256.2 **November 1, 2010 certain nursing facilities.** (a) Notwithstanding any other law to the
256.3 contrary, money available for moratorium projects under section 144A.073, subdivision
256.4 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception
256.5 project for a nursing facility in Bloomington licensed for 137 beds as of November 1,
256.6 2010, up to a total property rate adjustment of \$19.33.

256.7 (b) Effective June 1, 2012, any nursing facility in McLeod County licensed for 110
256.8 beds shall have its replacement-cost-new limit under subdivision 17e adjusted to allow
256.9 \$1,129,463 of a completed construction project to increase the property payment rate.
256.10 Notwithstanding any other law to the contrary, money available under section 144A.073,
256.11 subdivision 11, after the completion of the moratorium exception approval process in 2013
256.12 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the
256.13 medical assistance budget for the increase in the replacement-cost-new limit.

256.14 (c) Effective July 1, 2012, any nursing facility in Dakota County licensed for
256.15 61 beds shall have their replacement-cost-new limit under subdivision 17e adjusted to
256.16 allow \$1,407,624 of a completed construction project to increase their property payment
256.17 rate. Effective September 1, 2013, or later, their replacement-cost-new limit under
256.18 subdivision 17e shall be adjusted to allow \$1,244,599 of a completed construction project
256.19 to increase the property payment rate. Notwithstanding any other law to the contrary,
256.20 money available under section 144A.073, subdivision 11, after the completion of the
256.21 moratorium exception approval process in 2013 under section 144A.073, subdivision 3,
256.22 shall be used to reduce the fiscal impact to the medical assistance budget for the increase
256.23 in the replacement-cost-new limit.

256.24 (d) Effective July 1, 2013, or later, any boarding care facility in Hennepin
256.25 County licensed for 101 beds shall be allowed to receive a property rate adjustment
256.26 for a construction project that takes action to come into compliance with Minnesota
256.27 Department of Labor and Industry elevator upgrade requirements, with costs below the
256.28 minimum threshold under subdivision 16. Only costs related to the construction project
256.29 that brings the facility into compliance with the elevator requirements shall be allowed.
256.30 Notwithstanding any other law to the contrary, money available under section 144A.073,
256.31 subdivision 11, after the completion of the moratorium exception approval process in
256.32 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to
256.33 the medical assistance program.

256.34 **EFFECTIVE DATE.** Paragraph (b) is effective retroactively from June 1, 2012.
256.35 **Paragraph (c) is effective retroactively from July 1, 2012.**

257.1 Sec. 24. Minnesota Statutes 2012, section 256B.434, subdivision 4, is amended to read:

257.2 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
 257.3 have their payment rates determined under this section rather than section 256B.431, the
 257.4 commissioner shall establish a rate under this subdivision. The nursing facility must enter
 257.5 into a written contract with the commissioner.

257.6 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
 257.7 contract under this section is the payment rate the facility would have received under
 257.8 section 256B.431.

257.9 (c) A nursing facility's case mix payment rates for the second and subsequent years
 257.10 of a facility's contract under this section are the previous rate year's contract payment
 257.11 rates plus an inflation adjustment and, for facilities reimbursed under this section or
 257.12 section 256B.431, an adjustment to include the cost of any increase in Health Department
 257.13 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
 257.14 inflation adjustment must be based on the change in the Consumer Price Index-All Items
 257.15 (United States City average) (CPI-U) forecasted by the commissioner of management and
 257.16 budget's national economic consultant, as forecasted in the fourth quarter of the calendar
 257.17 year preceding the rate year. The inflation adjustment must be based on the 12-month
 257.18 period from the midpoint of the previous rate year to the midpoint of the rate year for
 257.19 which the rate is being determined. For the rate years beginning on July 1, 1999, July 1,
 257.20 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006,
 257.21 July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall
 257.22 apply only to the property-related payment rate. For the rate years beginning on October
 257.23 1, 2011, ~~and~~ October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, and
 257.24 October 1, 2016, the rate adjustment under this paragraph shall be suspended. Beginning
 257.25 in 2005, adjustment to the property payment rate under this section and section 256B.431
 257.26 shall be effective on October 1. In determining the amount of the property-related payment
 257.27 rate adjustment under this paragraph, the commissioner shall determine the proportion of
 257.28 the facility's rates that are property-related based on the facility's most recent cost report.

257.29 (d) The commissioner shall develop additional incentive-based payments of up to
 257.30 five percent above a facility's operating payment rate for achieving outcomes specified
 257.31 in a contract. The commissioner may solicit contract amendments and implement those
 257.32 which, on a competitive basis, best meet the state's policy objectives. The commissioner
 257.33 shall limit the amount of any incentive payment and the number of contract amendments
 257.34 under this paragraph to operate the incentive payments within funds appropriated for this
 257.35 purpose. The contract amendments may specify various levels of payment for various
 257.36 levels of performance. Incentive payments to facilities under this paragraph may be in the

258.1 form of time-limited rate adjustments or onetime supplemental payments. In establishing
258.2 the specified outcomes and related criteria, the commissioner shall consider the following
258.3 state policy objectives:

258.4 (1) successful diversion or discharge of residents to the residents' prior home or other
258.5 community-based alternatives;

258.6 (2) adoption of new technology to improve quality or efficiency;

258.7 (3) improved quality as measured in the Nursing Home Report Card;

258.8 (4) reduced acute care costs; and

258.9 (5) any additional outcomes proposed by a nursing facility that the commissioner
258.10 finds desirable.

258.11 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
258.12 take action to come into compliance with existing or pending requirements of the life
258.13 safety code provisions or federal regulations governing sprinkler systems must receive
258.14 reimbursement for the costs associated with compliance if all of the following conditions
258.15 are met:

258.16 (1) the expenses associated with compliance occurred on or after January 1, 2005,
258.17 and before December 31, 2008;

258.18 (2) the costs were not otherwise reimbursed under subdivision 4f or section
258.19 144A.071 or 144A.073; and

258.20 (3) the total allowable costs reported under this paragraph are less than the minimum
258.21 threshold established under section 256B.431, subdivision 15, paragraph (e), and
258.22 subdivision 16.

258.23 The commissioner shall use money appropriated for this purpose to provide to qualifying
258.24 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
258.25 2008. Nursing facilities that have spent money or anticipate the need to spend money
258.26 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
258.27 system or (2) replacing all or portions of an existing sprinkler system may submit to the
258.28 commissioner by June 30, 2007, on a form provided by the commissioner the actual
258.29 costs of a completed project or the estimated costs, based on a project bid, of a planned
258.30 project. The commissioner shall calculate a rate adjustment equal to the allowable
258.31 costs of the project divided by the resident days reported for the report year ending
258.32 September 30, 2006. If the costs from all projects exceed the appropriation for this
258.33 purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the
258.34 qualifying facilities by reducing the rate adjustment determined for each facility by an
258.35 equal percentage. Facilities that used estimated costs when requesting the rate adjustment
258.36 shall report to the commissioner by January 31, 2009, on the use of this money on a

259.1 form provided by the commissioner. If the nursing facility fails to provide the report, the
259.2 commissioner shall recoup the money paid to the facility for this purpose. If the facility
259.3 reports expenditures allowable under this subdivision that are less than the amount received
259.4 in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

259.5 Sec. 25. Minnesota Statutes 2012, section 256B.434, is amended by adding a
259.6 subdivision to read:

259.7 Subd. 19a. Nursing facility rate adjustments beginning September 1, 2013. A
259.8 total of a five percent average rate adjustment shall be provided as described under this
259.9 subdivision and under section 256B.441, subdivision 46b.

259.10 (a) Beginning September 1, 2013, the commissioner shall make available to each
259.11 nursing facility reimbursed under this section a 3.75 percent operating payment rate
259.12 increase, in accordance with paragraphs (b) to (g).

259.13 (b) Seventy-five percent of the money resulting from the rate adjustment under
259.14 paragraph (a) must be used for increases in compensation-related costs for employees
259.15 directly employed by the nursing facility on or after the effective date of the rate
259.16 adjustment, except:

259.17 (1) the administrator;

259.18 (2) persons employed in the central office of a corporation that has an ownership
259.19 interest in the nursing facility or exercises control over the nursing facility; and

259.20 (3) persons paid by the nursing facility under a management contract.

259.21 (c) The commissioner shall allow as compensation-related costs all costs for:

259.22 (1) wage and salary increases effective after May 25, 2013;

259.23 (2) the employer's share of FICA taxes, Medicare taxes, state and federal
259.24 unemployment taxes, and workers' compensation;

259.25 (3) the employer's share of health and dental insurance, life insurance, disability
259.26 insurance, long-term care insurance, uniform allowance, and pensions; and

259.27 (4) other benefits provided and workforce needs, including the recruiting and
259.28 training of employees, subject to the approval of the commissioner.

259.29 (d) The portion of the rate adjustment under paragraph (a) that is not subject to the
259.30 requirements of paragraph (b) shall be provided to nursing facilities effective September 1,
259.31 2013. Nursing facilities may apply for the portion of the rate adjustment under paragraph
259.32 (a) that is subject to the requirements in paragraph (b). The application must be submitted
259.33 to the commissioner within six months of the effective date of the rate adjustment, and
259.34 the nursing facility must provide additional information required by the commissioner
259.35 within nine months of the effective date of the rate adjustment. The commissioner must

260.1 respond to all applications within three weeks of receipt. The commissioner may waive
260.2 the deadlines in this paragraph under extraordinary circumstances, to be determined at the
260.3 sole discretion of the commissioner. The application must contain:

260.4 (1) an estimate of the amounts of money that must be used as specified in paragraph
260.5 (b);

260.6 (2) a detailed distribution plan specifying the allowable compensation-related
260.7 increases the nursing facility will implement to use the funds available in clause (1);

260.8 (3) a description of how the nursing facility will notify eligible employees of
260.9 the contents of the approved application, which must provide for giving each eligible
260.10 employee a copy of the approved application, excluding the information required in clause
260.11 (1), or posting a copy of the approved application, excluding the information required in
260.12 clause (1), for a period of at least six weeks in an area of the nursing facility to which all
260.13 eligible employees have access; and

260.14 (4) instructions for employees who believe they have not received the
260.15 compensation-related increases specified in clause (2), as approved by the commissioner,
260.16 and which must include a mailing address, e-mail address, and the telephone number
260.17 that may be used by the employee to contact the commissioner or the commissioner's
260.18 representative.

260.19 (e) The commissioner shall ensure that cost increases in distribution plans under
260.20 paragraph (d), clause (2), that may be included in approved applications, comply with the
260.21 following requirements:

260.22 (1) a portion of the costs resulting from tenure-related wage or salary increases
260.23 may be considered to be allowable wage increases, according to formulas that the
260.24 commissioner shall provide, where employee retention is above the average statewide
260.25 rate of retention of direct-care employees;

260.26 (2) the annualized amount of increases in costs for the employer's share of health
260.27 and dental insurance, life insurance, disability insurance, and workers' compensation
260.28 shall be allowable compensation-related increases if they are effective on or after April
260.29 1, 2013, and prior to April 1, 2014; and

260.30 (3) for nursing facilities in which employees are represented by an exclusive
260.31 bargaining representative, the commissioner shall approve the application only upon
260.32 receipt of a letter of acceptance of the distribution plan, in regard to members of the
260.33 bargaining unit, signed by the exclusive bargaining agent, and dated after May 25, 2013.
260.34 Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of
260.35 this provision as having been met in regard to the members of the bargaining unit.

261.1 (f) The commissioner shall review applications received under paragraph (d) and
261.2 shall provide the portion of the rate adjustment under paragraph (b) if the requirements
261.3 of this statute have been met. The rate adjustment shall be effective September 1, 2013.
261.4 Notwithstanding paragraph (a), if the approved application distributes less money than is
261.5 available, the amount of the rate adjustment shall be reduced so that the amount of money
261.6 made available is equal to the amount to be distributed.

261.7 (g) The increase in this subdivision shall be applied as a percentage to operating
261.8 payment rates in effect on August 31, 2013. For each facility, the commissioner shall
261.9 determine the operating payment rate, not including any rate components resulting from
261.10 equitable cost-sharing for publicly owned nursing facility program participation under
261.11 section 256B.441, subdivision 55a, critical access nursing facility program participation
261.12 under section 256B.441, subdivision 63, or performance-based incentive payment
261.13 program participation under subdivision 4, paragraph (d), for a RUG class with a weight
261.14 of 1.00 in effect on August 31, 2013.

261.15 Sec. 26. Minnesota Statutes 2012, section 256B.434, is amended by adding a
261.16 subdivision to read:

261.17 Subd. 19b. **Nursing facility rate adjustments beginning October 1, 2015.** A
261.18 total of a 3.2 percent average rate adjustment shall be provided as described under this
261.19 subdivision and under section 256B.441, subdivision 46c.

261.20 (a) Beginning October 1, 2015, the commissioner shall make available to each
261.21 nursing facility reimbursed under this section a 2.4 percent operating payment rate
261.22 increase, in accordance with paragraphs (b) to (g).

261.23 (b) Seventy-five percent of the money resulting from the rate adjustment under
261.24 paragraph (a) must be used for increases in compensation-related costs for employees
261.25 directly employed by the nursing facility on or after the effective date of the rate
261.26 adjustment, except:

261.27 (1) the administrator;

261.28 (2) persons employed in the central office of a corporation that has an ownership
261.29 interest in the nursing facility or exercises control over the nursing facility; and

261.30 (3) persons paid by the nursing facility under a management contract.

261.31 (c) The commissioner shall allow as compensation-related costs all costs for:

261.32 (1) wage and salary increases effective after May 25, 2015;

261.33 (2) the employer's share of FICA taxes, Medicare taxes, state and federal
261.34 unemployment taxes, and workers' compensation;

262.1 (3) the employer's share of health and dental insurance, life insurance, disability
262.2 insurance, long-term care insurance, uniform allowance, and pensions; and

262.3 (4) other benefits provided and workforce needs, including the recruiting and
262.4 training of employees, subject to the approval of the commissioner.

262.5 (d) The portion of the rate adjustment under paragraph (a) that is not subject to the
262.6 requirements of paragraph (b) shall be provided to nursing facilities effective October 1,
262.7 2015. Nursing facilities may apply for the portion of the rate adjustment under paragraph
262.8 (a) that is subject to the requirements in paragraph (b). The application must be submitted
262.9 to the commissioner within six months of the effective date of the rate adjustment, and
262.10 the nursing facility must provide additional information required by the commissioner
262.11 within nine months of the effective date of the rate adjustment. The commissioner must
262.12 respond to all applications within three weeks of receipt. The commissioner may waive
262.13 the deadlines in this paragraph under extraordinary circumstances, to be determined at the
262.14 sole discretion of the commissioner. The application must contain:

262.15 (1) an estimate of the amounts of money that must be used as specified in paragraph
262.16 (b);

262.17 (2) a detailed distribution plan specifying the allowable compensation-related
262.18 increases the nursing facility will implement to use the funds available in clause (1);

262.19 (3) a description of how the nursing facility will notify eligible employees of
262.20 the contents of the approved application, which must provide for giving each eligible
262.21 employee a copy of the approved application, excluding the information required in clause
262.22 (1), or posting a copy of the approved application, excluding the information required in
262.23 clause (1), for a period of at least six weeks in an area of the nursing facility to which all
262.24 eligible employees have access; and

262.25 (4) instructions for employees who believe they have not received the
262.26 compensation-related increases specified in clause (2), as approved by the commissioner,
262.27 and which must include a mailing address, e-mail address, and the telephone number
262.28 that may be used by the employee to contact the commissioner or the commissioner's
262.29 representative.

262.30 (e) The commissioner shall ensure that cost increases in distribution plans under
262.31 paragraph (d), clause (2), that may be included in approved applications, comply with the
262.32 following requirements:

262.33 (1) a portion of the costs resulting from tenure-related wage or salary increases
262.34 may be considered to be allowable wage increases, according to formulas that the
262.35 commissioner shall provide, where employee retention is above the average statewide
262.36 rate of retention of direct-care employees;

263.1 (2) the annualized amount of increases in costs for the employer's share of health
263.2 and dental insurance, life insurance, disability insurance, and workers' compensation
263.3 shall be allowable compensation-related increases if they are effective on or after April
263.4 1, 2015, and prior to April 1, 2016; and

263.5 (3) for nursing facilities in which employees are represented by an exclusive
263.6 bargaining representative, the commissioner shall approve the application only upon
263.7 receipt of a letter of acceptance of the distribution plan, in regard to members of the
263.8 bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2015.
263.9 Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of
263.10 this provision as having been met in regard to the members of the bargaining unit.

263.11 (f) The commissioner shall review applications received under paragraph (d) and
263.12 shall provide the portion of the rate adjustment under paragraph (b) if the requirements
263.13 of this statute have been met. The rate adjustment shall be effective October 1, 2015.
263.14 Notwithstanding paragraph (a), if the approved application distributes less money than is
263.15 available, the amount of the rate adjustment shall be reduced so that the amount of money
263.16 made available is equal to the amount to be distributed.

263.17 (g) The increase in this subdivision shall be applied as a percentage to operating
263.18 payment rates in effect on September 30, 2015. For each facility, the commissioner shall
263.19 determine the operating payment rate, not including any rate components resulting from
263.20 equitable cost-sharing for publicly owned nursing facility program participation under
263.21 section 256B.441, subdivision 55a, critical access nursing facility program participation
263.22 under section 256B.441, subdivision 63, or performance-based incentive payment
263.23 program participation under subdivision 4, paragraph (d), for a RUG class with a weight
263.24 of 1.00 in effect on September 30, 2015.

263.25 Sec. 27. Minnesota Statutes 2012, section 256B.437, subdivision 6, is amended to read:

263.26 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
263.27 services shall calculate the amount of the planned closure rate adjustment available under
263.28 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

263.29 (1) the amount available is the net reduction of nursing facility beds multiplied
263.30 by \$2,080;

263.31 (2) the total number of beds in the nursing facility or facilities receiving the planned
263.32 closure rate adjustment must be identified;

263.33 (3) capacity days are determined by multiplying the number determined under
263.34 clause (2) by 365; and

264.1 (4) the planned closure rate adjustment is the amount available in clause (1), divided
264.2 by capacity days determined under clause (3).

264.3 (b) A planned closure rate adjustment under this section is effective on the first day
264.4 of the month following completion of closure of the facility designated for closure in
264.5 the application and becomes part of the nursing facility's ~~total operating~~ external fixed
264.6 payment rate.

264.7 ~~(e) Applicants may use the planned closure rate adjustment to allow for a property~~
264.8 ~~payment for a new nursing facility or an addition to an existing nursing facility or as an~~
264.9 ~~operating payment rate adjustment. Applications approved under this subdivision are~~
264.10 ~~exempt from other requirements for moratorium exceptions under section 144A.073,~~
264.11 ~~subdivisions 2 and 3.~~

264.12 ~~(d)~~ (c) Upon the request of a closing facility, the commissioner must allow the
264.13 facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

264.14 ~~(e)~~ (d) A facility that has received a planned closure rate adjustment may reassign it
264.15 to another facility that is under the same ownership at any time within three years of its
264.16 effective date. The amount of the adjustment shall be computed according to paragraph (a).

264.17 ~~(f)~~ (e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
264.18 the commissioner shall recalculate planned closure rate adjustments for facilities that
264.19 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
264.20 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
264.21 from the date the per bed dollar amount is increased.

264.22 ~~(g)~~ (f) For planned closures approved after June 30, 2009, the commissioner of
264.23 human services shall calculate the amount of the planned closure rate adjustment available
264.24 under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

264.25 ~~(h) Beginning~~ (g) Between July 16, 2011, and June 30, 2013, the commissioner shall
264.26 ~~no longer~~ not accept applications for planned closure rate adjustments under subdivision 3.

264.27 Sec. 28. Minnesota Statutes 2012, section 256B.439, subdivision 1, is amended to read:

264.28 Subdivision 1. **Development and implementation of quality profiles.** (a) The
264.29 commissioner of human services, in cooperation with the commissioner of health,
264.30 shall develop and implement a quality ~~profile system~~ profiles for nursing facilities and,
264.31 beginning not later than July 1, ~~2004,~~ other providers of long-term care services 2014, for
264.32 home and community-based services providers, except when the quality profile system
264.33 would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. For
264.34 purposes of this section, home and community-based services providers are defined as
264.35 providers of home and community-based services under sections 256B.0913, 256B.0915,

265.1 256B.092, and 256B.49, and intermediate care facilities for persons with developmental
265.2 disabilities providers under section 256B.5013. To the extent possible, quality profiles
265.3 must be developed for providers of services to older adults and people with disabilities,
265.4 regardless of payor source, for the purposes of providing information to consumers. The
265.5 system quality profiles must be developed and implemented to the extent possible without
265.6 the collection of significant amounts of new data. To the extent possible, the system
265.7 using existing data sets maintained by the commissioners of health and human services
265.8 to the extent possible. The profiles must incorporate or be coordinated with information
265.9 on quality maintained by area agencies on aging, long-term care trade associations, the
265.10 ombudsman offices, counties, tribes, health plans, and other entities and the long-term
265.11 care database maintained under section 256.975, subdivision 7. The system profiles must
265.12 be designed to provide information on quality to:

- 265.13 (1) consumers and their families to facilitate informed choices of service providers;
265.14 (2) providers to enable them to measure the results of their quality improvement
265.15 efforts and compare quality achievements with other service providers; and
265.16 (3) public and private purchasers of long-term care services to enable them to
265.17 purchase high-quality care.

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

265.22 Sec. 29. Minnesota Statutes 2012, section 256B.439, subdivision 2, is amended to read:

265.23 Subd. 2. **Quality measurement tools for nursing facilities.** The commissioners
265.24 shall identify and apply existing quality measurement tools to:

- 265.25 (1) emphasize quality of care and its relationship to quality of life; and
265.26 (2) address the needs of various users of long-term care services, including, but not
265.27 limited to, short-stay residents, persons with behavioral problems, persons with dementia,
265.28 and persons who are members of minority groups.

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

265.31 Sec. 30. Minnesota Statutes 2012, section 256B.439, is amended by adding a
265.32 subdivision to read:

265.33 Subd. 2a. **Quality measurement tools for home and community-based services.**

265.34 (a) The commissioners shall identify and apply quality measurement tools to:

266.1 (1) emphasize service quality and its relationship to quality of life; and
266.2 (2) address the needs of various users of home and community-based services.
266.3 (b) The tools must include, but not be limited to, surveys of consumers of home
266.4 and community-based services. The tools must be identified and applied, to the extent
266.5 possible, without requiring providers to supply information beyond state and federal
266.6 requirements, for purposes of this subdivision.

266.7 Sec. 31. Minnesota Statutes 2012, section 256B.439, is amended by adding a
266.8 subdivision to read:

266.9 Subd. 3a. **Consumer surveys for home and community-based services.**

266.10 Following identification of the quality measurement tool, and within the limits of the
266.11 appropriation, the commissioner shall conduct surveys of home and community-based
266.12 services consumers to develop quality profiles of providers. To the extent possible, surveys
266.13 must be conducted face-to-face by state employees or contractors. At the discretion of
266.14 the commissioner, surveys may be conducted by an alternative method. Surveys must be
266.15 conducted periodically to update quality profiles of individual service providers.

266.16 Sec. 32. Minnesota Statutes 2012, section 256B.439, is amended by adding a
266.17 subdivision to read:

266.18 Subd. 5. **Implementation of home and community-based services**

266.19 **performance-based incentive payment program.** By April 1, 2014, the commissioner
266.20 shall develop incentive-based grants for home and community-based services providers
266.21 for achieving outcomes specified in a contract. The commissioner may solicit proposals
266.22 from home and community-based services providers and implement those that, on
266.23 a competitive basis, best meet the state's policy objectives. The commissioner shall
266.24 determine the types of home and community-based services providers that will participate
266.25 in the program. The determination of participating provider types may be revised annually
266.26 by the commissioner. The commissioner shall limit the amount of any incentive-based
266.27 grants and the number of grants under this subdivision to operate the incentive payments
266.28 within funds appropriated for this purpose. The grant agreements may specify various
266.29 levels of payment for various levels of performance. In establishing the specified outcomes
266.30 and related criteria, the commissioner shall consider the following state policy objectives:

266.31 (1) provide more efficient, higher quality services;

266.32 (2) encourage home and community-based services providers to innovate;

266.33 (3) equip home and community-based services providers with organizational tools
266.34 and expertise to improve their quality;

- 267.1 (4) incentivize home and community-based services providers to invest in better
267.2 services; and
267.3 (5) disseminate successful performance improvement strategies statewide.

267.4 Sec. 33. Minnesota Statutes 2012, section 256B.439, is amended by adding a
267.5 subdivision to read:

267.6 **Subd. 6. Calculation of home and community-based services quality score.**

267.7 (a) The commissioner shall determine a quality score for each participating home and
267.8 community-based services provider using quality measures established in subdivisions
267.9 1 and 2a, according to methods determined by the commissioner in consultation
267.10 with stakeholders and experts. These methods shall be exempt from the rulemaking
267.11 requirements under chapter 14.

267.12 (b) For each quality measure, a score shall be determined with a maximum number
267.13 of points available and number of points assigned as determined by the commissioner
267.14 using the methodology established according to this subdivision. The determination of
267.15 the quality measures to be used and the methods of calculating scores may be revised
267.16 annually by the commissioner.

267.17 Sec. 34. Minnesota Statutes 2012, section 256B.439, is amended by adding a
267.18 subdivision to read:

267.19 **Subd. 7. Calculation of home and community-based services quality add-on.**

267.20 Effective July 1, 2015, the commissioner shall determine the quality add-on payment
267.21 for participating home and community-based services providers. The payment rate for
267.22 the quality add-on shall be a variable amount based on each provider's quality score as
267.23 determined in subdivisions 1 and 2a. The commissioner shall limit the types of home and
267.24 community-based services providers that may receive the quality add-on and the amount
267.25 of the quality add-on payments to operate the quality add-on within funds appropriated for
267.26 this purpose and based on the availability of the quality measures.

267.27 Sec. 35. Minnesota Statutes 2012, section 256B.441, subdivision 44, is amended to read:

267.28 **Subd. 44. Calculation of a quality score.** (a) The commissioner shall determine
267.29 a quality score for each nursing facility using quality measures established in section
267.30 256B.439, according to methods determined by the commissioner in consultation
267.31 with stakeholders and experts. These methods shall be exempt from the rulemaking
267.32 requirements under chapter 14.

268.1 (b) For each quality measure, a score shall be determined with a maximum number
268.2 of points available and number of points assigned as determined by the commissioner
268.3 using the methodology established according to this subdivision. The scores determined
268.4 for all quality measures shall be totaled. The determination of the quality measures to be
268.5 used and the methods of calculating scores may be revised annually by the commissioner.

268.6 (c) For the initial rate year under the new payment system, the quality measures
268.7 shall include:

268.8 (1) staff turnover;

268.9 (2) staff retention;

268.10 (3) use of pool staff;

268.11 (4) quality indicators from the minimum data set; and

268.12 (5) survey deficiencies.

268.13 (d) ~~For rate years beginning after October 1, 2006, when making revisions to the~~
268.14 ~~quality measures or method for calculating scores, the commissioner shall publish the~~
268.15 ~~methodology in the State Register at least 15 months prior to the start of the rate year for~~
268.16 ~~which the revised methodology is to be used for rate-setting purposes. The quality score~~
268.17 ~~used to determine payment rates shall be established for a rate year using data submitted~~
268.18 ~~in the statistical and cost report from the associated reporting year, and using data from~~
268.19 ~~other sources related to a period beginning no more than six months prior to the associated~~
268.20 ~~reporting year~~ Beginning July 1, 2013, the quality score shall be a value between zero and
268.21 100, using data as provided in the Minnesota nursing home report card, with 50 percent
268.22 derived from the Minnesota quality indicators score, 40 percent derived from the resident
268.23 quality of life score, and ten percent derived from the state inspection results score.

268.24 (e) The commissioner, in cooperation with the commissioner of health, may adjust
268.25 the formula in paragraph (d), or the methodology for computing the total quality score,
268.26 effective July 1 of any year beginning in 2014, with five months advance public notice.
268.27 In changing the formula, the commissioner shall consider quality measure priorities
268.28 registered by report card users, advise of stakeholders, and available research.

268.29 Sec. 36. Minnesota Statutes 2012, section 256B.441, is amended by adding a
268.30 subdivision to read:

268.31 **Subd. 46b. Calculation of quality add-on, with an average value of 1.25 percent,**
268.32 **effective September 1, 2013.** (a) The commissioner shall determine quality add-ons to
268.33 the operating payment rates for each facility. The increase in this subdivision shall be
268.34 applied as a percentage to operating payment rates in effect on August 31, 2013. For each
268.35 facility, the commissioner shall determine the operating payment rate, not including any

269.1 rate components resulting from equitable cost-sharing for publicly owned nursing facility
269.2 program participation under subdivision 55a, critical access nursing facility program
269.3 participation under subdivision 63, or performance-based incentive payment program
269.4 participation under section 256B.434, subdivision 4, paragraph (d), for a RUG class with a
269.5 weight of 1.00 in effect on August 31, 2013.

269.6 (b) For each facility, the commissioner shall compute a quality factor by subtracting
269.7 40 from the most recent quality score computed under subdivision 44, and then dividing
269.8 by 60. If the quality factor is less than zero, the commissioner shall use the value zero.

269.9 (c) The quality add-ons shall be the operating payment rates determined in paragraph
269.10 (a), multiplied by the quality factor determined in paragraph (b), and then multiplied by
269.11 3.2 percent. The commissioner shall implement the quality add-ons effective September
269.12 1, 2013.

269.13 Sec. 37. Minnesota Statutes 2012, section 256B.441, is amended by adding a
269.14 subdivision to read:

269.15 Subd. 46c. **Quality improvement incentive system beginning October 1, 2015.**

269.16 The commissioner shall develop a quality improvement incentive program in consultation
269.17 with stakeholders. The annual funding pool available for quality improvement incentive
269.18 payments shall be equal to 0.8 percent of all operating payments, not including any rate
269.19 components resulting from equitable cost-sharing for publicly owned nursing facility
269.20 program participation under subdivision 55a, critical access nursing facility program
269.21 participation under subdivision 63, or performance-based incentive payment program
269.22 participation under section 256B.434, subdivision 4, paragraph (d). Beginning October 1,
269.23 2015, annual rate adjustments provided under this subdivision shall be effective for one
269.24 year, starting October 1 and ending the following September 30.

269.25 Sec. 38. Minnesota Statutes 2012, section 256B.49, subdivision 11a, is amended to read:

269.26 Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall
269.27 establish statewide priorities for individuals on the waiting list for community alternative
269.28 care, community alternatives for disabled individuals, and brain injury waiver services,
269.29 as of January 1, 2010. The statewide priorities must include, but are not limited to,
269.30 individuals who continue to have a need for waiver services after they have maximized the
269.31 use of state plan services and other funding resources, including natural supports, prior to
269.32 accessing waiver services, and who meet at least one of the following criteria:

269.33 (1) no longer require the intensity of services provided where they are currently
269.34 living; or

270.1 (2) make a request to move from an institutional setting.

270.2 (b) After the priorities in paragraph (a) are met, priority must also be given to
270.3 individuals who meet at least one of the following criteria:

270.4 (1) have unstable living situations due to the age, incapacity, or sudden loss of
270.5 the primary caregivers;

270.6 (2) are moving from an institution due to bed closures;

270.7 (3) experience a sudden closure of their current living arrangement;

270.8 (4) require protection from confirmed abuse, neglect, or exploitation;

270.9 (5) experience a sudden change in need that can no longer be met through state plan
270.10 services or other funding resources alone; or

270.11 (6) meet other priorities established by the department.

270.12 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
270.13 consideration the number of individuals waiting who meet statewide priorities and the
270.14 lead agencies' current use of waiver funds and existing service options. The commissioner
270.15 has the authority to transfer funds between counties, groups of counties, and tribes to
270.16 accommodate statewide priorities and resource needs while accounting for a necessary
270.17 base level reserve amount for each county, group of counties, and tribe.

270.18 ~~(e) The commissioner shall evaluate the impact of the use of statewide priorities and~~
270.19 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
270.20 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
270.21 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

270.22 Sec. 39. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

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

270.33 (b) There must be a determination that the client requires a hospital level of care or a
270.34 nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph

271.1 (d), at initial and subsequent assessments to initiate and maintain participation in the
271.2 waiver program.

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

271.9 (d) Recipients who are found eligible for home and community-based services under
271.10 this section before their 65th birthday may remain eligible for these services after their
271.11 65th birthday if they continue to meet all other eligibility factors.

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

271.23 Sec. 40. Minnesota Statutes 2012, section 256B.49, subdivision 15, is amended to read:

271.24 Subd. 15. **Coordinated service and support plan; comprehensive transitional**
271.25 **service plan; maintenance service plan.** (a) Each recipient of home and community-based
271.26 waived services shall be provided a copy of the written coordinated service and support
271.27 plan which meets the requirements in section 256B.092, subdivision 1b.

271.28 (b) In developing the comprehensive transitional service plan, the individual
271.29 receiving services, the case manager, and the guardian, if applicable, will identify the
271.30 transitional service plan fundamental service outcome and anticipated timeline to achieve
271.31 this outcome. Within the first 20 days following a recipient's request for an assessment or
271.32 reassessment, the transitional service planning team must be identified. A team leader must
271.33 be identified who will be responsible for assigning responsibility and communicating with
271.34 team members to ensure implementation of the transition plan and ongoing assessment and

272.1 communication process. The team leader should be an individual, such as the case manager
272.2 or guardian, who has the opportunity to follow the recipient to the next level of service.

272.3 Within ten days following an assessment, a comprehensive transitional service plan
272.4 must be developed incorporating elements of a comprehensive functional assessment and
272.5 including short-term measurable outcomes and timelines for achievement of and reporting
272.6 on these outcomes. Functional milestones must also be identified and reported according
272.7 to the timelines agreed upon by the transitional service planning team. In addition, the
272.8 comprehensive transitional service plan must identify additional supports that may assist
272.9 in the achievement of the fundamental service outcome such as the development of greater
272.10 natural community support, increased collaboration among agencies, and technological
272.11 supports.

272.12 The timelines for reporting on functional milestones will prompt a reassessment of
272.13 services provided, the units of services, rates, and appropriate service providers. It is
272.14 the responsibility of the transitional service planning team leader to review functional
272.15 milestone reporting to determine if the milestones are consistent with observable skills
272.16 and that milestone achievement prompts any needed changes to the comprehensive
272.17 transitional service plan.

272.18 For those whose fundamental transitional service outcome involves the need to
272.19 procure housing, a plan for the recipient to seek the resources necessary to secure the least
272.20 restrictive housing possible should be incorporated into the plan, including employment
272.21 and public supports such as housing access and shelter needy funding.

272.22 (c) Counties and other agencies responsible for funding community placement and
272.23 ongoing community supportive services are responsible for the implementation of the
272.24 comprehensive transitional service plans. Oversight responsibilities include both ensuring
272.25 effective transitional service delivery and efficient utilization of funding resources.

272.26 (d) Following one year of transitional services, the transitional services planning team
272.27 will make a determination as to whether or not the individual receiving services requires
272.28 the current level of continuous and consistent support in order to maintain the recipient's
272.29 current level of functioning. Recipients who are determined to have not had a significant
272.30 change in functioning for 12 months must move from a transitional to a maintenance
272.31 service plan. Recipients on a maintenance service plan must be reassessed to determine if
272.32 the recipient would benefit from a transitional service plan at least every 12 months and at
272.33 other times when there has been a significant change in the recipient's functioning. This
272.34 assessment should consider any changes to technological or natural community supports.

272.35 (e) When a county is evaluating denials, reductions, or terminations of home and
272.36 community-based services under section 256B.49 for an individual, the case manager

273.1 shall offer to meet with the individual or the individual's guardian in order to discuss
273.2 the prioritization of service needs within the coordinated service and support plan,
273.3 comprehensive transitional service plan, or maintenance service plan. The reduction in
273.4 the authorized services for an individual due to changes in funding for waived services
273.5 may not exceed the amount needed to ensure medically necessary services to meet the
273.6 individual's health, safety, and welfare.

273.7 (f) At the time of reassessment, local agency case managers shall assess each recipient
273.8 of community alternatives for disabled individuals or brain injury waived services
273.9 currently residing in a licensed adult foster home that is not the primary residence of the
273.10 license holder, or in which the license holder is not the primary caregiver, to determine if
273.11 that recipient could appropriately be served in a community-living setting. If appropriate
273.12 for the recipient, the case manager shall offer the recipient, through a person-centered
273.13 planning process, the option to receive alternative housing and service options. In the
273.14 event that the recipient chooses to transfer from the adult foster home, the vacated bed
273.15 shall not be filled with another recipient of waiver services and group residential housing
273.16 and the licensed capacity shall be reduced accordingly, unless the savings required by the
273.17 licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7,
273.18 sections 1 and 40, paragraph (f), for foster care settings where the physical location is not
273.19 the primary residence of the license holder are met through voluntary changes described
273.20 in section 245A.03, subdivision 7, paragraph ~~(f)~~ (e), or as provided under paragraph (a),
273.21 clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers,
273.22 the county agency, with the assistance of the department, shall facilitate a consolidation of
273.23 settings or closure. This reassessment process shall be completed by July 1, 2013.

273.24 Sec. 41. Minnesota Statutes 2012, section 256B.49, is amended by adding a
273.25 subdivision to read:

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

273.34 (1) conduct a functional assessment of the crisis incident as defined in section
273.35 245D.02, subdivision 11, which led to the hospitalization with the goal of developing

274.1 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
274.2 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

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

274.15 Subd. 26. **Excess allocations.** County and tribal agencies will be responsible for
274.16 authorizations in excess of the allocation made by the commissioner. In the event a county
274.17 or tribal agency authorizes in excess of the allocation made by the commissioner for a
274.18 given allocation period, the county or tribal agency must submit a corrective action plan to
274.19 the commissioner. The plan must state the actions the agency will take to correct their
274.20 overspending for the year following the period when the overspending occurred. Failure
274.21 to correct overauthorizations shall result in recoupment of authorizations in excess of
274.22 the allocation. Nothing in this subdivision shall be construed as reducing the county's
274.23 responsibility to offer and make available feasible home and community-based options to
274.24 eligible waiver recipients within the resources allocated to them for that purpose.

274.25 Sec. 43. Minnesota Statutes 2012, section 256B.492, is amended to read:

274.26 **256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE**
274.27 **WITH DISABILITIES.**

274.28 (a) Individuals receiving services under a home and community-based waiver under
274.29 section 256B.092 or 256B.49 may receive services in the following settings:

274.30 (1) an individual's own home or family home;

274.31 (2) a licensed adult foster care setting of up to five people; and

274.32 (3) community living settings as defined in section 256B.49, subdivision 23, where
274.33 individuals with disabilities may reside in all of the units in a building of four or fewer
274.34 units, and no more than the greater of four or 25 percent of the units in a multifamily

275.1 building of more than four units, unless required by the Housing Opportunities for Persons
275.2 with AIDS Program.

275.3 (b) The settings in paragraph (a) must not:

275.4 (1) be located in a building that is a publicly or privately operated facility that
275.5 provides institutional treatment or custodial care;

275.6 (2) be located in a building on the grounds of or adjacent to a public or private
275.7 institution;

275.8 (3) be a housing complex designed expressly around an individual's diagnosis or
275.9 disability, unless required by the Housing Opportunities for Persons with AIDS Program;

275.10 (4) be segregated based on a disability, either physically or because of setting
275.11 characteristics, from the larger community; and

275.12 (5) have the qualities of an institution which include, but are not limited to:
275.13 regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions
275.14 agreed to and documented in the person's individual service plan shall not result in a
275.15 residence having the qualities of an institution as long as the restrictions for the person are
275.16 not imposed upon others in the same residence and are the least restrictive alternative,
275.17 imposed for the shortest possible time to meet the person's needs.

275.18 (c) The provisions of paragraphs (a) and (b) do not apply to any setting in which
275.19 individuals receive services under a home and community-based waiver as of July 1,
275.20 2012, and the setting does not meet the criteria of this section.

275.21 (d) Notwithstanding paragraph (c), a program in Hennepin County established as
275.22 part of a Hennepin County demonstration project is qualified for the exception allowed
275.23 under paragraph (c).

275.24 (e) The commissioner shall submit an amendment to the waiver plan no later than
275.25 December 31, 2012.

275.26 Sec. 44. Minnesota Statutes 2012, section 256B.493, subdivision 2, is amended to read:

275.27 Subd. 2. **Planned closure process needs determination.** The commissioner shall
275.28 announce and implement a program for planned closure of adult foster care homes. Planned
275.29 closure shall be the preferred method for achieving necessary budgetary savings required by
275.30 the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph ~~(d)~~
275.31 (c). If additional closures are required to achieve the necessary savings, the commissioner
275.32 shall use the process and priorities in section 245A.03, subdivision 7, paragraph ~~(d)~~ (c).

275.33 Sec. 45. Minnesota Statutes 2012, section 256B.501, is amended by adding a
275.34 subdivision to read:

276.1 Subd. 14. Rate adjustment for ICF/DD in Cottonwood County. The
276.2 commissioner of health shall decertify three beds in an intermediate care facility for
276.3 persons with developmental disabilities with 21 certified beds located in Cottonwood
276.4 County. The total payment rate shall be \$282.62 per bed, per day.

276.5 Sec. 46. Minnesota Statutes 2012, section 256B.5012, is amended by adding a
276.6 subdivision to read:

276.7 Subd. 14. Rate increase effective June 1, 2013. For rate periods beginning on or
276.8 after June 1, 2013, the commissioner shall increase the total operating payment rate for
276.9 each facility reimbursed under this section by \$7.81 per day. The increase shall not be
276.10 subject to any annual percentage increase.

276.11 **EFFECTIVE DATE.** This section is effective June 1, 2013.

276.12 Sec. 47. Minnesota Statutes 2012, section 256B.5012, is amended by adding a
276.13 subdivision to read:

276.14 Subd. 15. ICF/DD rate increases effective April 1, 2014. (a) Notwithstanding
276.15 subdivision 12, for each facility reimbursed under this section, for the rate period
276.16 beginning April 1, 2014, the commissioner shall increase operating payments equal to one
276.17 percent of the operating payment rates in effect on March 31, 2014.

276.18 (b) For each facility, the commissioner shall apply the rate increase based on
276.19 occupied beds, using the percentage specified in this subdivision multiplied by the total
276.20 payment rate, including the variable rate, but excluding the property-related payment
276.21 rate in effect on the preceding date. The total rate increase shall include the adjustment
276.22 provided in section 256B.501, subdivision 12.

276.23 Sec. 48. Minnesota Statutes 2012, section 256B.69, is amended by adding a
276.24 subdivision to read:

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

277.1 (b) The following information from encounter data provided to the commissioner
277.2 shall be reported on the department's public Web site for each managed care plan and
277.3 county-based purchasing plan annually by July 31 of each year beginning in 2014:

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

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

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

277.9 (4) the types of treatments provided to children identified under clause (2) listed by
277.10 billing code, including the number of units billed for each child.

277.11 (c) The managed care plans and county-based purchasing plans shall also report on
277.12 any barriers to providing screening, diagnosis, and treatment of young children between
277.13 the ages of one and three years, any strategies implemented to address those barriers,
277.14 and make recommendations on how to measure and report on the effectiveness of the
277.15 strategies implemented to facilitate access for young children to provide developmental
277.16 and social-emotional screening, diagnosis, and treatment as described in paragraph (a).

277.17 Sec. 49. **[256B.85] COMMUNITY FIRST SERVICES AND SUPPORTS.**

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

277.22 (b) CFSS is a participant-controlled method of selecting and providing services
277.23 and supports that allows the participant maximum control of the services and supports.
277.24 Participants may choose the degree to which they direct and manage their supports by
277.25 choosing to have a significant and meaningful role in the management of services and
277.26 supports including by directly employing support workers with the necessary supports
277.27 to perform that function.

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

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

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

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

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

278.12 (d) "Behavior" means a description of a need for services and supports used to
278.13 determine the home care rating and additional service units. The presence of Level I
278.14 behavior is used to determine the home care rating. "Level I behavior" means physical
278.15 aggression towards self or others or destruction of property that requires the immediate
278.16 response of another person. If qualified for a home care rating as described in subdivision
278.17 8, additional service units can be added as described in subdivision 8, paragraph (f), for
278.18 the following behaviors:

278.19 (1) Level I behavior;

278.20 (2) increased vulnerability due to cognitive deficits or socially inappropriate
278.21 behavior; or

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

278.24 (e) "Complex health-related needs" means an intervention listed in clauses (1) to
278.25 (8) that has been ordered by a physician, and is specified in a community support plan,
278.26 including:

278.27 (1) tube feedings requiring:

278.28 (i) a gastrojejunostomy tube; or

278.29 (ii) continuous tube feeding lasting longer than 12 hours per day;

278.30 (2) wounds described as:

278.31 (i) stage III or stage IV;

278.32 (ii) multiple wounds;

278.33 (iii) requiring sterile or clean dressing changes or a wound vac; or

278.34 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require
278.35 specialized care;

278.36 (3) parenteral therapy described as:

- 279.1 (i) IV therapy more than two times per week lasting longer than four hours for
279.2 each treatment; or
- 279.3 (ii) total parenteral nutrition (TPN) daily;
279.4 (4) respiratory interventions, including:
279.5 (i) oxygen required more than eight hours per day;
279.6 (ii) respiratory vest more than one time per day;
279.7 (iii) bronchial drainage treatments more than two times per day;
279.8 (iv) sterile or clean suctioning more than six times per day;
279.9 (v) dependence on another to apply respiratory ventilation augmentation devices
279.10 such as BiPAP and CPAP; and
- 279.11 (vi) ventilator dependence under section 256B.0652;
279.12 (5) insertion and maintenance of catheter, including:
279.13 (i) sterile catheter changes more than one time per month;
279.14 (ii) clean intermittent catheterization, and including self-catheterization more than
279.15 six times per day; or
- 279.16 (iii) bladder irrigations;
279.17 (6) bowel program more than two times per week requiring more than 30 minutes to
279.18 perform each time;
- 279.19 (7) neurological intervention, including:
279.20 (i) seizures more than two times per week and requiring significant physical
279.21 assistance to maintain safety; or
279.22 (ii) swallowing disorders diagnosed by a physician and requiring specialized
279.23 assistance from another on a daily basis; and
- 279.24 (8) other congenital or acquired diseases creating a need for significantly increased
279.25 direct hands-on assistance and interventions in six to eight activities of daily living.
- 279.26 (f) "Community first services and supports" or "CFSS" means the assistance and
279.27 supports program under this section needed for accomplishing activities of daily living,
279.28 instrumental activities of daily living, and health-related tasks through hands-on assistance
279.29 to accomplish the task or constant supervision and cueing to accomplish the task, or the
279.30 purchase of goods as defined in subdivision 7, paragraph (a), clause (3), that replace
279.31 the need for human assistance.
- 279.32 (g) "Community first services and supports service delivery plan" or "service delivery
279.33 plan" means a written summary of the services and supports, that is based on the community
279.34 support plan identified in section 256B.0911 and coordinated services and support plan
279.35 and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined
279.36 by the participant to meet the assessed needs, using a person-centered planning process.

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

280.3 (i) "Dependency" in activities of daily living means a person requires hands-on
280.4 assistance or constant supervision and cueing to accomplish one or more of the activities
280.5 of daily living every day or on the days during the week that the activity is performed;
280.6 however, a child may not be found to be dependent in an activity of daily living if,
280.7 because of the child's age, an adult would either perform the activity for the child or assist
280.8 the child with the activity and the assistance needed is the assistance appropriate for
280.9 a typical child of the same age.

280.10 (j) "Extended CFSS" means CFSS services and supports under the agency-provider
280.11 model included in a service plan through one of the home and community-based services
280.12 waivers authorized under sections 256B.0915; 256B.092, subdivision 5; and 256B.49,
280.13 which exceed the amount, duration, and frequency of the state plan CFSS services for
280.14 participants.

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

280.22 (l) "Budget model" means a service delivery method of CFSS that allows the use of
280.23 an individualized CFSS service delivery plan and service budget and provides assistance
280.24 from the financial management services contractor to facilitate participant employment of
280.25 support workers and the acquisition of supports and goods.

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

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

280.35 (o) "Legal representative" means parent of a minor, a court-appointed guardian, or
280.36 another representative with legal authority to make decisions about services and supports

281.1 for the participant. Other representatives with legal authority to make decisions include
281.2 but are not limited to a health care agent or an attorney-in-fact authorized through a health
281.3 care directive or power of attorney.

281.4 (p) "Medication assistance" means providing verbal or visual reminders to take
281.5 regularly scheduled medication, and includes any of the following supports listed in clauses
281.6 (1) to (3) and other types of assistance, except that a support worker may not determine
281.7 medication dose or time for medication or inject medications into veins, muscles, or skin:

281.8 (1) under the direction of the participant or the participant's representative, bringing
281.9 medications to the participant including medications given through a nebulizer, opening a
281.10 container of previously set-up medications, emptying the container into the participant's
281.11 hand, opening and giving the medication in the original container to the participant, or
281.12 bringing to the participant liquids or food to accompany the medication;

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

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

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

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

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

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

281.35 (r) "Person-centered planning process" means a process that is directed by the
281.36 participant to plan for services and supports. The person-centered planning process must:

282.1 (1) include people chosen by the participant;
282.2 (2) provide necessary information and support to ensure that the participant directs
282.3 the process to the maximum extent possible, and is enabled to make informed choices
282.4 and decisions;

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

282.6 (4) reflect cultural considerations of the participant;

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

282.9 (6) provide the participant choices of the services and supports they receive and the
282.10 staff providing those services and supports;

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

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

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

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

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

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

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

282.27 (u) "Support worker" means an employee of the agency provider or of the participant
282.28 who has direct contact with the participant and provides services as specified within the
282.29 participant's service delivery plan.

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

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

283.1 (1) is a recipient of medical assistance as determined under section 256B.055,
283.2 256B.056, or 256B.057, subdivisions 5 and 9;

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

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

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

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

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

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

283.13 (3) lives in the person's own apartment or home including a family foster care setting
283.14 licensed under chapter 245A, but not in corporate foster care under chapter 245A; or a
283.15 noncertified boarding care or boarding and lodging establishments under chapter 157.

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

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

283.20 (1) be conducted by a certified assessor according to the criteria established in
283.21 section 256B.0911, subdivision 3a;

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

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

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

283.29 (c) The results of the assessment and any recommendations and authorizations for
283.30 CFSS must be determined and communicated in writing by the lead agency's certified
283.31 assessor as defined in section 256B.0911 to the participant and the agency-provider or
283.32 financial management services provider chosen by the participant within 40 calendar days
283.33 and must include the participant's right to appeal under section 256.045, subdivision 3.

283.34 (d) The lead agency assessor may request a temporary authorization for CFSS
283.35 services. Authorization for a temporary level of CFSS services is limited to the time

284.1 specified by the commissioner, but shall not exceed 45 days. The level of services
284.2 authorized under this provision shall have no bearing on a future authorization.

284.3 Subd. 6. **Community first services and support service delivery plan.** (a) The
284.4 CFSS service delivery plan must be developed, implemented, and evaluated through a
284.5 person-centered planning process by the participant, or the participant's representative
284.6 or legal representative who may be assisted by a support specialist. The CFSS service
284.7 delivery plan must reflect the services and supports that are important to the participant
284.8 and for the participant to meet the needs assessed by the certified assessor and identified in
284.9 the community support plan under section 256B.0911, subdivision 3, or the coordinated
284.10 services and support plan identified in section 256B.0915, subdivision 6, if applicable. The
284.11 CFSS service delivery plan must be reviewed by the participant and the agency-provider
284.12 or financial management services contractor at least annually upon reassessment, or
284.13 when there is a significant change in the participant's condition, or a change in the need
284.14 for services and supports.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

285.9 Subd. 7. **Community first services and supports; covered services.** Within the
285.10 service unit authorization or budget allocation, services and supports covered under
285.11 CFSS include:

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

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

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

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

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

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

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

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

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

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

285.36 (6) transition costs, including:

- 286.1 (i) deposits for rent and utilities;
286.2 (ii) first month's rent and utilities;
286.3 (iii) bedding;
286.4 (iv) basic kitchen supplies;
286.5 (v) other necessities, to the extent that these necessities are not otherwise covered
286.6 under any other funding that the participant is eligible to receive; and
286.7 (vi) other required necessities for an individual to make the transition from a nursing
286.8 facility, institution for mental diseases, or intermediate care facility for persons with
286.9 developmental disabilities to a community-based home setting where the participant
286.10 resides; and
286.11 (7) services by a support specialist defined under subdivision 2 that are chosen
286.12 by the participant.

286.13 **Subd. 8. Determination of CFSS service methodology.** (a) All community first
286.14 services and supports must be authorized by the commissioner or the commissioner's
286.15 designee before services begin, except for the assessments established in section
286.16 256B.0911. The authorization for CFSS must be completed as soon as possible following
286.17 an assessment but no later than 40 calendar days from the date of the assessment.

286.18 (b) The amount of CFSS authorized must be based on the recipient's home care
286.19 rating described in subdivision 8, paragraphs (d) and (e), and any additional service units
286.20 for which the person qualifies as described in subdivision 8, paragraph (f).

286.21 (c) The home care rating shall be determined by the commissioner or the
286.22 commissioner's designee based on information submitted to the commissioner identifying
286.23 the following for a recipient:

286.24 (1) the total number of dependencies of activities of daily living as defined in
286.25 subdivision 2, paragraph (b);

286.26 (2) the presence of complex health-related needs as defined in subdivision 2,
286.27 paragraph (e); and

286.28 (3) the presence of Level I behavior as defined in subdivision 2, paragraph (d),
286.29 clause (1).

286.30 (d) The methodology to determine the total service units for CFSS for each home
286.31 care rating is based on the median paid units per day for each home care rating from
286.32 fiscal year 2007 data for the PCA program.

286.33 (e) Each home care rating is designated by the letters P through Z and EN and has
286.34 the following base number of service units assigned:

286.35 (i) P home care rating requires Level 1 behavior or one to three dependencies in
286.36 ADLs and qualifies one for five service units;

287.1 (ii) Q home care rating requires Level 1 behavior and one to three dependencies in
287.2 ADLs and qualifies one for six service units;

287.3 (iii) R home care rating requires a complex health-related need and one to three
287.4 dependencies in ADLs and qualifies one for seven service units;

287.5 (iv) S home care rating requires four to six dependencies in ADLs and qualifies
287.6 one for ten service units;

287.7 (v) T home care rating requires four to six dependencies in ADLs and Level 1
287.8 behavior and qualifies one for 11 service units;

287.9 (vi) U home care rating requires four to six dependencies in ADLs and a complex
287.10 health need and qualifies one for 14 service units;

287.11 (vii) V home care rating requires seven to eight dependencies in ADLs and qualifies
287.12 one for 17 service units;

287.13 (viii) W home care rating requires seven to eight dependencies in ADLs and Level 1
287.14 behavior and qualifies one for 20 service units;

287.15 (ix) Z home care rating requires seven to eight dependencies in ADLs and a complex
287.16 health related need and qualifies one for 30 service units; and

287.17 (x) EN home care rating includes ventilator dependency as defined in section
287.18 256B.0651, subdivision 1, paragraph (g). Recipients who meet the definition of
287.19 ventilator-dependent and the EN home care rating and utilize a combination of CFSS
287.20 and other home care services are limited to a total of 96 service units per day for those
287.21 services in combination. Additional units may be authorized when a recipient's assessment
287.22 indicates a need for two staff to perform activities. Additional time is limited to 16 service
287.23 units per day.

287.24 (f) Additional service units are provided through the assessment and identification of
287.25 the following:

287.26 (1) 30 additional minutes per day for a dependency in each critical activity of daily
287.27 living as defined in subdivision 2, paragraph (h);

287.28 (2) 30 additional minutes per day for each complex health-related function as
287.29 defined in subdivision 2, paragraph (e); and

287.30 (3) 30 additional minutes per day for each behavior issue as defined in subdivision 2,
287.31 paragraph (d).

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

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

- 288.1 (2) are provided prior to the authorization of services and the approval of the written
288.2 CFSS service delivery plan;
- 288.3 (3) are duplicative of other paid services in the written service delivery plan;
288.4 (4) supplant natural unpaid supports that appropriately meet a need in the service
288.5 plan, are provided voluntarily to the participant and are selected by the participant in lieu
288.6 of other services and supports;
- 288.7 (5) are not effective means to meet the participant's needs; and
288.8 (6) are available through other funding sources, including, but not limited to, funding
288.9 through Title IV-E of the Social Security Act.
- 288.10 (b) Additional services, goods, or supports that are not covered include:
- 288.11 (1) those that are not for the direct benefit of the participant, except that services for
288.12 caregivers such as training to improve the ability to provide CFSS are considered to directly
288.13 benefit the participant if chosen by the participant and approved in the support plan;
- 288.14 (2) any fees incurred by the participant, such as Minnesota health care programs fees
288.15 and co-pays, legal fees, or costs related to advocate agencies;
- 288.16 (3) insurance, except for insurance costs related to employee coverage;
288.17 (4) room and board costs for the participant with the exception of allowable
288.18 transition costs in subdivision 7, clause (6);
- 288.19 (5) services, supports, or goods that are not related to the assessed needs;
288.20 (6) special education and related services provided under the Individuals with
288.21 Disabilities Education Act and vocational rehabilitation services provided under the
288.22 Rehabilitation Act of 1973;
- 288.23 (7) assistive technology devices and assistive technology services other than those
288.24 for back-up systems or mechanisms to ensure continuity of service and supports listed in
288.25 subdivision 7;
- 288.26 (8) medical supplies and equipment;
288.27 (9) environmental modifications, except as specified in subdivision 7;
288.28 (10) expenses for travel, lodging, or meals related to training the participant, the
288.29 participant's representative, legal representative, or paid or unpaid caregivers that exceed
288.30 \$500 in a 12-month period;
- 288.31 (11) experimental treatments;
288.32 (12) any service or good covered by other medical assistance state plan services,
288.33 including prescription and over-the-counter medications, compounds, and solutions and
288.34 related fees, including premiums and co-payments;
- 288.35 (13) membership dues or costs, except when the service is necessary and appropriate
288.36 to treat a physical condition or to improve or maintain the participant's physical condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

289.30 (11) report maltreatment as required under sections 626.556 and 626.557; and

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

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

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

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

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

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

290.16 (f) The agency-provider model must be used by individuals who have been restricted
290.17 by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160
290.18 to 9505.2245.

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

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

290.25 (2) proof of surety bond coverage. Upon new enrollment, or if the provider agency's
290.26 Medicaid revenue in the previous calendar year is less than or equal to \$300,000, the
290.27 provider agency must purchase a performance bond of \$50,000. If the provider agency's
290.28 Medicaid revenue in the previous calendar year is greater than \$300,000, the provider
290.29 agency must purchase a performance bond of \$100,000. The performance bond must be
290.30 in a form approved by the commissioner, must be renewed annually, and must allow for
290.31 recovery of costs and fees in pursuing a claim on the bond;

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

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

290.34 (5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

291.26 (14) documentation that the agency does not burden recipients' free exercise of their
291.27 right to choose service providers by requiring personal care assistants to sign an agreement
291.28 not to work with any particular CFSS recipient or for another CFSS provider agency after
291.29 leaving the agency and that the agency is not taking action on any such agreements or
291.30 requirements regardless of the date signed.

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

291.33 (c) All CFSS provider agencies shall require all employees in management and
291.34 supervisory positions and owners of the agency who are active in the day-to-day
291.35 management and operations of the agency to complete mandatory training as determined
291.36 by the commissioner. Employees in management and supervisory positions and owners

292.1 who are active in the day-to-day operations of an agency who have completed the required
292.2 training as an employee with a CFSS provider agency do not need to repeat the required
292.3 training if they are hired by another agency, if they have completed the training within
292.4 the past three years. CFSS provider agency billing staff shall complete training about
292.5 CFSS program financial management. Any new owners or employees in management
292.6 and supervisory positions involved in the day-to-day operations are required to complete
292.7 mandatory training as a requisite of working for the agency. CFSS provider agencies
292.8 certified for participation in Medicare as home health agencies are exempt from the
292.9 training required in this subdivision.

292.10 Subd. 13. **Budget model.** (a) Under the budget model participants can exercise
292.11 more responsibility and control over the services and supports described and budgeted
292.12 within the CFSS service delivery plan. Under this model, participants may use their
292.13 budget allocation to:

292.14 (1) directly employ support workers;

292.15 (2) obtain supports and goods as defined in subdivision 7; and

292.16 (3) choose a range of support assistance services from the financial management
292.17 services (FMS) contractor related to:

292.18 (i) assistance in managing the budget to meet the service delivery plan needs,
292.19 consistent with federal and state laws and regulations;

292.20 (ii) the employment, training, supervision, and evaluation of workers by the
292.21 participant;

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

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

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

292.27 (c) The FMS contractor shall not provide CFSS services and supports under the
292.28 agency-provider service model. The FMS contractor shall provide service functions as
292.29 determined by the commissioner that include but are not limited to:

292.30 (1) information and consultation about CFSS;

292.31 (2) assistance with the development of the service delivery plan and budget model
292.32 as requested by the participant;

292.33 (3) billing and making payments for budget model expenditures;

292.34 (4) assisting participants in fulfilling employer-related requirements according to
292.35 Internal Revenue Code Procedure 70-6, section 3504, Agency Employer Tax Liability,

293.1 regulation 137036-08, which includes assistance with filing and paying payroll taxes, and
293.2 obtaining worker compensation coverage;

293.3 (5) data recording and reporting of participant spending; and

293.4 (6) other duties established in the contract with the department, including with
293.5 respect to providing assistance to the participant, participant's representative, or legal
293.6 representative in performing their employer responsibilities regarding support workers.

293.7 The support worker shall not be considered the employee of the financial management
293.8 services contractor.

293.9 (d) A participant who requests to purchase goods and supports along with support
293.10 worker services under the agency-provider model must use the budget model with
293.11 a service delivery plan that specifies the amount of services to be authorized to the
293.12 agency-provider and the expenditures to be paid by the FMS contractor.

293.13 (e) The FMS contractor shall:

293.14 (1) not limit or restrict the participant's choice of service or support providers or
293.15 service delivery models consistent with any applicable state and federal requirements;

293.16 (2) provide the participant and the targeted case manager, if applicable, with a
293.17 monthly written summary of the spending for services and supports that were billed
293.18 against the spending budget;

293.19 (3) be knowledgeable of state and federal employment regulations, including those
293.20 under the Fair Labor Standards Act of 1938, and comply with the requirements under the
293.21 Internal Revenue Service Revenue Code Procedure 70-6, Section 35-4, Agency Employer
293.22 Tax Liability for vendor or fiscal employer agent, and any requirements necessary to
293.23 process employer and employee deductions, provide appropriate and timely submission of
293.24 employer tax liabilities, and maintain documentation to support medical assistance claims;

293.25 (4) have current and adequate liability insurance and bonding and sufficient cash
293.26 flow as determined by the commissioner and have on staff or under contract a certified
293.27 public accountant or an individual with a baccalaureate degree in accounting;

293.28 (5) assume fiscal accountability for state funds designated for the program; and

293.29 (6) maintain documentation of receipts, invoices, and bills to track all services and
293.30 supports expenditures for any goods purchased and maintain time records of support
293.31 workers. The documentation and time records must be maintained for a minimum of
293.32 five years from the claim date and be available for audit or review upon request by the
293.33 commissioner. Claims submitted by the FMS contractor to the commissioner for payment
293.34 must correspond with services, amounts, and time periods as authorized in the participant's
293.35 spending budget and service plan.

293.36 (f) The commissioner of human services shall:

294.1 (1) establish rates and payment methodology for the FMS contractor;
294.2 (2) identify a process to ensure quality and performance standards for the FMS
294.3 contractor and ensure statewide access to FMS contractors; and

294.4 (3) establish a uniform protocol for delivering and administering CFSS services
294.5 to be used by eligible FMS contractors.

294.6 (g) The commissioner of human services shall disenroll or exclude participants from
294.7 the budget model and transfer them to the agency-provider model under the following
294.8 circumstances that include but are not limited to:

294.9 (1) when a participant has been restricted by the Minnesota restricted recipient
294.10 program, the participant may be excluded for a specified time period under Minnesota
294.11 Rules, parts 9505.2160 to 9505.2245;

294.12 (2) when a participant exits the budget model during the participant's service plan
294.13 year. Upon transfer, the participant shall not access the budget model for the remainder of
294.14 that service plan year; or

294.15 (3) when the department determines that the participant or participant's representative
294.16 or legal representative cannot manage participant responsibilities under the budget model.
294.17 The commissioner must develop policies for determining if a participant is unable to
294.18 manage responsibilities under a budget model.

294.19 (h) A participant may appeal under section 256.045, subdivision 3, in writing to the
294.20 department to contest the department's decision under paragraph (c), clause (3), to remove
294.21 or exclude the participant from the budget model.

294.22 **Subd. 14. Participant's responsibilities under budget model.** (a) A participant
294.23 using the budget model must use an FMS contractor or vendor that is under contract with
294.24 the department. Upon a determination of eligibility and completion of the assessment and
294.25 community support plan, the participant shall choose a FMS contractor from a list of
294.26 eligible vendors maintained by the department.

294.27 (b) When the participant, participant's representative, or legal representative
294.28 chooses to be the employer of the support worker, they are responsible for the hiring and
294.29 supervision of the support worker, including, but not limited to, recruiting, interviewing,
294.30 training, scheduling, and discharging the support worker consistent with federal and
294.31 state laws and regulations.

294.32 (c) In addition to the employer responsibilities in paragraph (b), the participant,
294.33 participant's representative, or legal representative is responsible for:

294.34 (1) tracking the services provided and all expenditures for goods or other supports;

295.1 (2) preparing and submitting time sheets, signed by both the participant and support
295.2 worker, to the FMS contractor on a regular basis and in a timely manner according to
295.3 the FMS contractor's procedures;

295.4 (3) notifying the FMS contractor within ten days of any changes in circumstances
295.5 affecting the CFSS service plan or in the participant's place of residence including, but
295.6 not limited to, any hospitalization of the participant or change in the participant's address,
295.7 telephone number, or employment;

295.8 (4) notifying the FMS contractor of any changes in the employment status of each
295.9 participant support worker; and

295.10 (5) reporting any problems resulting from the quality of services rendered by the
295.11 support worker to the FMS contractor. If the participant is unable to resolve any problems
295.12 resulting from the quality of service rendered by the support worker with the assistance of
295.13 the FMS contractor, the participant shall report the situation to the department.

295.14 Subd. 15. **Documentation of support services provided.** (a) Support services
295.15 provided to a participant by a support worker employed by either an agency-provider
295.16 or the participant acting as the employer must be documented daily by each support
295.17 worker, on a time sheet form approved by the commissioner. All documentation may be
295.18 Web-based, electronic, or paper documentation. The completed form must be submitted
295.19 on a monthly basis to the provider or the participant and the FMS contractor selected by
295.20 the participant to provide assistance with meeting the participant's employer obligations
295.21 and kept in the recipient's health record.

295.22 (b) The activity documentation must correspond to the written service delivery plan
295.23 and be reviewed by the agency provider or the participant and the FMS contractor when
295.24 the participant is acting as the employer of the support worker.

295.25 (c) The time sheet must be on a form approved by the commissioner documenting
295.26 time the support worker provides services in the home. The following criteria must be
295.27 included in the time sheet:

295.28 (1) full name of the support worker and individual provider number;

295.29 (2) provider name and telephone numbers, if an agency-provider is responsible for
295.30 delivery services under the written service plan;

295.31 (3) full name of the participant;

295.32 (4) consecutive dates, including month, day, and year, and arrival and departure
295.33 times with a.m. or p.m. notations;

295.34 (5) signatures of the participant or the participant's representative;

295.35 (6) personal signature of the support worker;

295.36 (7) any shared care provided, if applicable;

296.1 (8) a statement that it is a federal crime to provide false information on CFSS
296.2 billings for medical assistance payments; and

296.3 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

296.4 Subd. 16. **Support workers requirements.** (a) Support workers shall:

296.5 (1) enroll with the department as a support worker after a background study under
296.6 chapter 245C has been completed and the support worker has received a notice from the
296.7 commissioner that:

296.8 (i) the support worker is not disqualified under section 245C.14; or

296.9 (ii) is disqualified, but the support worker has received a set-aside of the
296.10 disqualification under section 245C.22;

296.11 (2) have the ability to effectively communicate with the participant or the
296.12 participant's representative;

296.13 (3) have the skills and ability to provide the services and supports according to the
296.14 person's CFSS service delivery plan and respond appropriately to the participant's needs;

296.15 (4) not be a participant of CFSS, unless the support services provided by the support
296.16 worker differ from those provided to the support worker;

296.17 (5) complete the basic standardized training as determined by the commissioner
296.18 before completing enrollment. The training must be available in languages other than
296.19 English and to those who need accommodations due to disabilities. Support worker
296.20 training must include successful completion of the following training components: basic
296.21 first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles
296.22 and responsibilities of support workers including information about basic body mechanics,
296.23 emergency preparedness, orientation to positive behavioral practices, orientation to
296.24 responding to a mental health crisis, fraud issues, time cards and documentation, and an
296.25 overview of person-centered planning and self-direction. Upon completion of the training
296.26 components, the support worker must pass the certification test to provide assistance
296.27 to participants;

296.28 (6) complete training and orientation on the participant's individual needs; and

296.29 (7) maintain the privacy and confidentiality of the participant, and not independently
296.30 determine the medication dose or time for medications for the participant.

296.31 (b) The commissioner may deny or terminate a support worker's provider enrollment
296.32 and provider number if the support worker:

296.33 (1) lacks the skills, knowledge, or ability to adequately or safely perform the
296.34 required work;

296.35 (2) fails to provide the authorized services required by the participant employer;

297.1 (3) has been intoxicated by alcohol or drugs while providing authorized services to
297.2 the participant or while in the participant's home;

297.3 (4) has manufactured or distributed drugs while providing authorized services to the
297.4 participant or while in the participant's home; or

297.5 (5) has been excluded as a provider by the commissioner of human services, or the
297.6 United States Department of Health and Human Services, Office of Inspector General,
297.7 from participation in Medicaid, Medicare, or any other federal health care program.

297.8 (c) A support worker may appeal in writing to the commissioner to contest the
297.9 decision to terminate the support worker's provider enrollment and provider number.

297.10 Subd. 17. **Support specialist requirements and payments.** The commissioner
297.11 shall develop qualifications, scope of functions, and payment rates and service limits for a
297.12 support specialist that may provide additional or specialized assistance necessary to plan,
297.13 implement, arrange, augment, or evaluate services and supports.

297.14 Subd. 18. **Service unit and budget allocation requirements and limits.** (a) For the
297.15 agency-provider model, services will be authorized in units of service. The total service
297.16 unit amount must be established based upon the assessed need for CFSS services, and must
297.17 not exceed the maximum number of units available as determined under subdivision 8.

297.18 (b) For the budget model, the budget allocation allowed for services and supports
297.19 is established by multiplying the number of units authorized under subdivision 8 by the
297.20 payment rate established by the commissioner.

297.21 Subd. 19. **Support system.** (a) The commissioner shall provide information,
297.22 consultation, training, and assistance to ensure the participant is able to manage the
297.23 services and supports and budgets, if applicable. This support shall include individual
297.24 consultation on how to select and employ workers, manage responsibilities under CFSS,
297.25 and evaluate personal outcomes.

297.26 (b) The commissioner shall provide assistance with the development of risk
297.27 management agreements.

297.28 Subd. 20. **Service-related rights.** (a) Participants must be provided with adequate
297.29 information, counseling, training, and assistance, as needed, to ensure that the participant
297.30 is able to choose and manage services, models, and budgets. This support shall include
297.31 information regarding:

297.32 (1) person-centered planning;

297.33 (2) the range and scope of individual choices;

297.34 (3) the process for changing plans, services and budgets;

297.35 (4) the grievance process;

297.36 (5) individual rights;

298.1 (6) identifying and assessing appropriate services;

298.2 (7) risks and responsibilities; and

298.3 (8) risk management.

298.4 (b) The commissioner must ensure that the participant has a copy of the most recent
298.5 community support plan and service delivery plan.

298.6 (c) A participant who appeals a reduction in previously authorized CFSS services
298.7 may continue previously authorized services pending an appeal in accordance with section
298.8 256.045.

298.9 (d) If the units of service or budget allocation for CFSS are reduced, denied, or
298.10 terminated, the commissioner must provide notice of the reasons for the reduction in the
298.11 participant's notice of denial, termination, or reduction.

298.12 (e) If all or part of a service delivery plan is denied approval, the commissioner must
298.13 provide a notice that describes the basis of the denial.

298.14 Subd. 21. **Development and Implementation Council.** The commissioner
298.15 shall establish a Development and Implementation Council of which the majority of
298.16 members are individuals with disabilities, elderly individuals, and their representatives.
298.17 The commissioner shall consult and collaborate with the council when developing and
298.18 implementing this section for at least the first five years of operation. The commissioner,
298.19 in consultation with the council, shall provide recommendations on how to improve the
298.20 quality and integrity of CFSS, reduce the paper documentation required in subdivisions
298.21 10, 12, and 15, make use of electronic means of documentation and online reporting in
298.22 order to reduce administrative costs and improve training to the legislative chairs of the
298.23 health and human services policy and finance committees by February 1, 2014.

298.24 Subd. 22. **Quality assurance and risk management system.** (a) The commissioner
298.25 shall establish quality assurance and risk management measures for use in developing and
298.26 implementing CFSS, including those that (1) recognize the roles and responsibilities of
298.27 those involved in obtaining CFSS, and (2) ensure the appropriateness of such plans and
298.28 budgets based upon a recipient's resources and capabilities. Risk management measures
298.29 must include background studies, and backup and emergency plans, including disaster
298.30 planning.

298.31 (b) The commissioner shall provide ongoing technical assistance and resource and
298.32 educational materials for CFSS participants.

298.33 (c) Performance assessment measures, such as a participant's satisfaction with the
298.34 services and supports, and ongoing monitoring of health and well-being shall be identified
298.35 in consultation with the council established in subdivision 21.

299.1 (d) Data reporting requirements will be developed in consultation with the council
299.2 established in subdivision 21.

299.3 Subd. 23. Commissioner's access. When the commissioner is investigating a
299.4 possible overpayment of Medicaid funds, the commissioner must be given immediate
299.5 access without prior notice to the agency provider or FMS contractor's office during
299.6 regular business hours and to documentation and records related to services provided and
299.7 submission of claims for services provided. Denying the commissioner access to records
299.8 is cause for immediate suspension of payment and terminating the agency provider's
299.9 enrollment according to section 256B.064 or terminating the FMS contract.

299.10 Subd. 24. CFSS agency-providers; background studies. CFSS agency-providers
299.11 enrolled to provide personal care assistance services under the medical assistance program
299.12 shall comply with the following:

299.13 (1) owners who have a five percent interest or more and all managing employees
299.14 are subject to a background study as provided in chapter 245C. This applies to currently
299.15 enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS
299.16 agency-provider. "Managing employee" has the same meaning as Code of Federal
299.17 Regulations, title 42, section 455. An organization is barred from enrollment if:

299.18 (i) the organization has not initiated background studies on owners managing
299.19 employees; or

299.20 (ii) the organization has initiated background studies on owners and managing
299.21 employees, but the commissioner has sent the organization a notice that an owner or
299.22 managing employee of the organization has been disqualified under section 245C.14, and
299.23 the owner or managing employee has not received a set-aside of the disqualification
299.24 under section 245C.22;

299.25 (2) a background study must be initiated and completed for all support specialists; and

299.26 (3) a background study must be initiated and completed for all support workers.

299.27 Subd. 25. Commissioner recommendations required. In consultation with
299.28 the Development and Implementation Council described in subdivision 21 and other
299.29 stakeholders, the commissioner shall develop recommendations for revisions to
299.30 subdivisions 12, 15, and 16, that promote self-direction in the following areas:

299.31 (1) CFSS provider and support worker enrollment, qualification, and disqualification
299.32 criteria;

299.33 (2) documentation requirements that are consistent with state and federal
299.34 requirements; and

299.35 (3) provisions to maintain program integrity and assure fiscal accountability for
299.36 goods and services purchased through CFSS.

300.1 The recommendations shall be provided to the chairs and ranking minority members
300.2 of the legislative committees and divisions with jurisdiction over health and human
300.3 services policy and finance by November 15, 2013.

300.4 **EFFECTIVE DATE.** This section is effective upon federal approval but no earlier
300.5 than April 1, 2014. The service will begin 90 days after federal approval or April 1,
300.6 2014, whichever is later. The commissioner of human services shall notify the revisor of
300.7 statutes when this occurs.

300.8 Sec. 50. Minnesota Statutes 2012, section 256D.44, subdivision 5, is amended to read:

300.9 Subd. 5. **Special needs.** In addition to the state standards of assistance established in
300.10 subdivisions 1 to 4, payments are allowed for the following special needs of recipients of
300.11 Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
300.12 center, or a group residential housing facility.

300.13 (a) The county agency shall pay a monthly allowance for medically prescribed
300.14 diets if the cost of those additional dietary needs cannot be met through some other
300.15 maintenance benefit. The need for special diets or dietary items must be prescribed by
300.16 a licensed physician. Costs for special diets shall be determined as percentages of the
300.17 allotment for a one-person household under the thrifty food plan as defined by the United
300.18 States Department of Agriculture. The types of diets and the percentages of the thrifty
300.19 food plan that are covered are as follows:

300.20 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

300.21 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent
300.22 of thrifty food plan;

300.23 (3) controlled protein diet, less than 40 grams and requires special products, 125
300.24 percent of thrifty food plan;

300.25 (4) low cholesterol diet, 25 percent of thrifty food plan;

300.26 (5) high residue diet, 20 percent of thrifty food plan;

300.27 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;

300.28 (7) gluten-free diet, 25 percent of thrifty food plan;

300.29 (8) lactose-free diet, 25 percent of thrifty food plan;

300.30 (9) antidumping diet, 15 percent of thrifty food plan;

300.31 (10) hypoglycemic diet, 15 percent of thrifty food plan; or

300.32 (11) ketogenic diet, 25 percent of thrifty food plan.

300.33 (b) Payment for nonrecurring special needs must be allowed for necessary home
300.34 repairs or necessary repairs or replacement of household furniture and appliances using

301.1 the payment standard of the AFDC program in effect on July 16, 1996, for these expenses,
301.2 as long as other funding sources are not available.

301.3 (c) A fee for guardian or conservator service is allowed at a reasonable rate
301.4 negotiated by the county or approved by the court. This rate shall not exceed five percent
301.5 of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the
301.6 guardian or conservator is a member of the county agency staff, no fee is allowed.

301.7 (d) The county agency shall continue to pay a monthly allowance of \$68 for
301.8 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
301.9 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
301.10 until the person has not received Minnesota supplemental aid for one full calendar month
301.11 or until the person's living arrangement changes and the person no longer meets the criteria
301.12 for the restaurant meal allowance, whichever occurs first.

301.13 (e) A fee of ten percent of the recipient's gross income or \$25, whichever is less,
301.14 is allowed for representative payee services provided by an agency that meets the
301.15 requirements under SSI regulations to charge a fee for representative payee services. This
301.16 special need is available to all recipients of Minnesota supplemental aid regardless of
301.17 their living arrangement.

301.18 (f)(1) Notwithstanding the language in this subdivision, an amount equal to the
301.19 maximum allotment authorized by the federal Food Stamp Program for a single individual
301.20 which is in effect on the first day of July of each year will be added to the standards of
301.21 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify
301.22 as shelter needy and are: (i) relocating from an institution, or an adult mental health
301.23 residential treatment program under section 256B.0622; (ii) eligible for the self-directed
301.24 supports option as defined under section 256B.0657, subdivision 2; or (iii) home and
301.25 community-based waiver recipients living in their own home or rented or leased apartment
301.26 which is not owned, operated, or controlled by a provider of service not related by blood
301.27 or marriage, unless allowed under paragraph (g).

301.28 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the
301.29 shelter needy benefit under this paragraph is considered a household of one. An eligible
301.30 individual who receives this benefit prior to age 65 may continue to receive the benefit
301.31 after the age of 65.

301.32 (3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that
301.33 exceed 40 percent of the assistance unit's gross income before the application of this
301.34 special needs standard. "Gross income" for the purposes of this section is the applicant's or
301.35 recipient's income as defined in section 256D.35, subdivision 10, or the standard specified
301.36 in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or

302.1 state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be
 302.2 considered shelter needy for purposes of this paragraph.

302.3 (g) Notwithstanding this subdivision, to access housing and services as provided
 302.4 in paragraph (f), the recipient may choose housing that may be owned, operated, or
 302.5 controlled by the recipient's service provider. In a multifamily building of more than four
 302.6 units, the maximum number of units that may be used by recipients of this program shall
 302.7 be the greater of four units or 25 percent of the units in the building, unless required by the
 302.8 Housing Opportunities for Persons with AIDS Program. In multifamily buildings of four
 302.9 or fewer units, all of the units may be used by recipients of this program. When housing is
 302.10 controlled by the service provider, the individual may choose the individual's own service
 302.11 provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is
 302.12 controlled by the service provider, the service provider shall implement a plan with the
 302.13 recipient to transition the lease to the recipient's name. Within two years of signing the
 302.14 initial lease, the service provider shall transfer the lease entered into under this subdivision
 302.15 to the recipient. In the event the landlord denies this transfer, the commissioner may
 302.16 approve an exception within sufficient time to ensure the continued occupancy by the
 302.17 recipient. This paragraph expires June 30, 2016.

302.18 Sec. 51. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
 302.19 3, as amended by Laws 2012, chapter 247, article 4, section 43, is amended to read:

302.20 **Subd. 3. Forecasted Programs**

302.21 The amounts that may be spent from this
 302.22 appropriation for each purpose are as follows:

302.23 **(a) MFIP/DWP Grants**

	Appropriations by Fund	
302.24		
302.25	General	84,680,000 91,978,000
302.26	Federal TANF	84,425,000 75,417,000

302.27 **(b) MFIP Child Care Assistance Grants** 55,456,000 30,923,000

302.28 **(c) General Assistance Grants** 49,192,000 46,938,000

302.29 **General Assistance Standard.** The
 302.30 commissioner shall set the monthly standard
 302.31 of assistance for general assistance units
 302.32 consisting of an adult recipient who is
 302.33 childless and unmarried or living apart

303.1 from parents or a legal guardian at \$203.
 303.2 The commissioner may reduce this amount
 303.3 according to Laws 1997, chapter 85, article
 303.4 3, section 54.

303.5 **Emergency General Assistance.** The
 303.6 amount appropriated for emergency general
 303.7 assistance funds is limited to no more than
 303.8 \$6,689,812 in fiscal year 2012 and \$6,729,812
 303.9 in fiscal year 2013. Funds to counties shall
 303.10 be allocated by the commissioner using the
 303.11 allocation method specified in Minnesota
 303.12 Statutes, section 256D.06.

303.13	(d) Minnesota Supplemental Aid Grants	38,095,000	39,120,000
303.14	(e) Group Residential Housing Grants	121,080,000	129,238,000
303.15	(f) MinnesotaCare Grants	295,046,000	317,272,000

303.16 This appropriation is from the health care
 303.17 access fund.

303.18	(g) Medical Assistance Grants	4,501,582,000	4,437,282,000
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303.19 **Managed Care Incentive Payments.** The
 303.20 commissioner shall not make managed care
 303.21 incentive payments for expanding preventive
 303.22 services during fiscal years beginning July 1,
 303.23 2011, and July 1, 2012.

303.24 **Reduction of Rates for Congregate**
 303.25 **Living for Individuals with Lower Needs.**
 303.26 Beginning October 1, 2011, lead agencies
 303.27 must reduce rates in effect on January 1, 2011,
 303.28 by ten percent for individuals with lower
 303.29 needs living in foster care settings where the
 303.30 license holder does not share the residence
 303.31 with recipients on the CADI and DD waivers
 303.32 and customized living settings for CADI.
 303.33 Lead agencies shall consult with providers to
 303.34 review individual service plans and identify

304.1 changes or modifications to reduce the
304.2 utilization of services while maintaining the
304.3 health and safety of the individual receiving
304.4 services. Lead agencies must adjust contracts
304.5 within 60 days of the effective date. If
304.6 federal waiver approval is obtained under
304.7 the long-term care realignment waiver
304.8 application submitted on February 13,
304.9 2012, and federal financial participation is
304.10 authorized for the alternative care program,
304.11 the commissioner shall adjust this payment
304.12 rate reduction from ten to five percent for
304.13 services rendered on or after July 1, 2012, or
304.14 the first day of the month following federal
304.15 approval, whichever is later. Effective
304.16 August 1, 2013, this provision does not apply
304.17 to individuals whose primary diagnosis is
304.18 mental illness and who are living in foster
304.19 care settings where the license holder is
304.20 also (1) a provider of assertive community
304.21 treatment (ACT) or adult rehabilitative
304.22 mental health services (ARMHS) as defined
304.23 in Minnesota Statutes, section 256B.0623;
304.24 (2) a mental health center or mental health
304.25 clinic certified under Minnesota Rules, parts
304.26 9520.0750 to 9520.0870; or (3) a provider
304.27 of intensive residential treatment services
304.28 (IRTS) licensed under Minnesota Rules,
304.29 parts 9520.0500 to 9520.0670.

304.30 **Reduction of Lead Agency Waiver**
304.31 **Allocations to Implement Rate Reductions**
304.32 **for Congregate Living for Individuals**
304.33 **with Lower Needs.** Beginning October 1,
304.34 2011, the commissioner shall reduce lead
304.35 agency waiver allocations to implement the
304.36 reduction of rates for individuals with lower

305.1 needs living in foster care settings where the
305.2 license holder does not share the residence
305.3 with recipients on the CADI and DD waivers
305.4 and customized living settings for CADI.

305.5 **Reduce customized living and 24-hour**
305.6 **customized living component rates.**

305.7 Effective July 1, 2011, the commissioner
305.8 shall reduce elderly waiver customized living
305.9 and 24-hour customized living component
305.10 service spending by five percent through
305.11 reductions in component rates and service
305.12 rate limits. The commissioner shall adjust
305.13 the elderly waiver capitation payment
305.14 rates for managed care organizations paid
305.15 under Minnesota Statutes, section 256B.69,
305.16 subdivisions 6a and 23, to reflect reductions
305.17 in component spending for customized living
305.18 services and 24-hour customized living
305.19 services under Minnesota Statutes, section
305.20 256B.0915, subdivisions 3e and 3h, for the
305.21 contract period beginning January 1, 2012.
305.22 To implement the reduction specified in
305.23 this provision, capitation rates paid by the
305.24 commissioner to managed care organizations
305.25 under Minnesota Statutes, section 256B.69,
305.26 shall reflect a ten percent reduction for the
305.27 specified services for the period January 1,
305.28 2012, to June 30, 2012, and a five percent
305.29 reduction for those services on or after July
305.30 1, 2012.

305.31 **Limit Growth in the Developmental**
305.32 **Disability Waiver.** The commissioner
305.33 shall limit growth in the developmental
305.34 disability waiver to six diversion allocations
305.35 per month beginning July 1, 2011, through
305.36 June 30, 2013, and 15 diversion allocations

306.1 per month beginning July 1, 2013, through
306.2 June 30, 2015. Waiver allocations shall
306.3 be targeted to individuals who meet the
306.4 priorities for accessing waiver services
306.5 identified in Minnesota Statutes, 256B.092,
306.6 subdivision 12. The limits do not include
306.7 conversions from intermediate care facilities
306.8 for persons with developmental disabilities.
306.9 Notwithstanding any contrary provisions in
306.10 this article, this paragraph expires June 30,
306.11 2015.

306.12 **Limit Growth in the Community**

306.13 **Alternatives for Disabled Individuals**

306.14 **Waiver.** The commissioner shall limit
306.15 growth in the community alternatives for
306.16 disabled individuals waiver to 60 allocations
306.17 per month beginning July 1, 2011, through
306.18 June 30, 2013, and 85 allocations per
306.19 month beginning July 1, 2013, through
306.20 June 30, 2015. Waiver allocations must
306.21 be targeted to individuals who meet the
306.22 priorities for accessing waiver services
306.23 identified in Minnesota Statutes, section
306.24 256B.49, subdivision 11a. The limits include
306.25 conversions and diversions, unless the
306.26 commissioner has approved a plan to convert
306.27 funding due to the closure or downsizing
306.28 of a residential facility or nursing facility
306.29 to serve directly affected individuals on
306.30 the community alternatives for disabled
306.31 individuals waiver. Notwithstanding any
306.32 contrary provisions in this article, this
306.33 paragraph expires June 30, 2015.

306.34 **Personal Care Assistance Relative**

306.35 **Care.** The commissioner shall adjust the
306.36 capitation payment rates for managed care

307.1 organizations paid under Minnesota Statutes,
 307.2 section 256B.69, to reflect the rate reductions
 307.3 for personal care assistance provided by
 307.4 a relative pursuant to Minnesota Statutes,
 307.5 section 256B.0659, subdivision 11. This rate
 307.6 reduction is effective July 1, 2013.

307.7	(h) Alternative Care Grants	46,421,000		46,035,000
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307.8 **Alternative Care Transfer.** Any money
 307.9 allocated to the alternative care program that
 307.10 is not spent for the purposes indicated does
 307.11 not cancel but shall be transferred to the
 307.12 medical assistance account.

307.13	(i) Chemical Dependency Entitlement Grants	94,675,000		93,298,000
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307.14 **EFFECTIVE DATE.** This section is effective August 1, 2013.

307.15 Sec. 52. Laws 2012, chapter 247, article 6, section 4, is amended to read:

307.16	Sec. 4. BOARD OF NURSING HOME			
307.17	ADMINISTRATORS	\$	-0-	\$ 10,000

307.18 **Administrative Services Unit.** This
 307.19 appropriation is to provide a grant to the
 307.20 Minnesota Ambulance Association to
 307.21 coordinate and prepare an assessment of
 307.22 the extent and costs of uncompensated care
 307.23 as a direct result of emergency responses
 307.24 on interstate highways in Minnesota.
 307.25 The study will collect appropriate
 307.26 information from medical response units
 307.27 and ambulance services regulated under
 307.28 Minnesota Statutes, chapter 144E, and to
 307.29 the extent possible, firefighting agencies.
 307.30 In preparing the assessment, the Minnesota
 307.31 Ambulance Association shall consult with
 307.32 its membership, the Minnesota Fire Chiefs
 307.33 Association, the Office of the State Fire

308.1 Marshal, and the Emergency Medical
308.2 Services Regulatory Board. The findings
308.3 of the assessment will be reported to the
308.4 chairs and ranking minority members of the
308.5 legislative committees with jurisdiction over
308.6 health and public safety by January 1, 2013.
308.7 This is a onetime appropriation.

308.8 Sec. 53. **RECOMMENDATIONS FOR CONCENTRATION LIMITS ON HOME**
308.9 **AND COMMUNITY-BASED SETTINGS.**

308.10 The commissioner of human services shall consult with the Minnesota Olmstead
308.11 subcabinet, advocates, providers, and city representatives to develop recommendations
308.12 on concentration limits on home and community-based settings, as defined in
308.13 Minnesota Statutes, section 256B.492, as well as any other exceptions to the definition.
308.14 The recommendations must be consistent with Minnesota's Olmstead plan. The
308.15 recommendations and proposed legislation must be submitted to the chairs and ranking
308.16 minority members of the legislative committees with jurisdiction over health and human
308.17 services policy and finance by February 1, 2014.

308.18 Sec. 54. **TRAINING OF AUTISM SERVICE PROVIDERS.**

308.19 The commissioners of health and human services shall ensure that the departments'
308.20 autism-related service providers receive training in culturally appropriate approaches to
308.21 servicing the Somali, Latino, Hmong, and Indigenous American Indian communities, and
308.22 other cultural groups experiencing a disproportionate incidence of autism.

308.23 Sec. 55. **DIRECTION TO COMMISSIONER; SPOUSAL DISREGARD.**

308.24 The commissioner of human services shall request authority, in whatever form is
308.25 necessary, from the federal Centers for Medicare and Medicaid Services to allow persons
308.26 under age 65 participating in the home and community-based services waivers to continue
308.27 to use the disregard of the nonassisted spouse's income and assets instead of the spousal
308.28 impoverishment provisions under the federal Patient Protection and Affordable Care Act,
308.29 Public Law 111-148, section 2404, as amended by the federal Health Care and Education
308.30 Reconciliation Act of 2010, Public Law 111-152, and any amendments to, or regulations
308.31 or guidance issued under, those acts.

308.32 Sec. 56. **DIRECTION TO COMMISSIONER; ABA.**

309.1 By January 1, 2014, the commissioner of human services shall apply to the federal
309.2 Centers for Medicare and Medicaid Services for a waiver or other authority to provide
309.3 applied behavioral analysis services to children with autism spectrum disorder and related
309.4 conditions under the medical assistance program.

309.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

309.6 Sec. 57. **RECOMMENDATIONS ON RAISING THE ASSET LIMITS FOR**
309.7 **SENIORS AND PERSONS WITH DISABILITIES.**

309.8 The commissioner of human services shall consult with interested stakeholders to
309.9 develop recommendations and a request for a federal 1115 demonstration waiver in order
309.10 to increase the asset limit for individuals eligible for medical assistance due to disability
309.11 or age who are not residing in a nursing facility, intermediate care facility for persons
309.12 with developmental disabilities, or other institution whose costs for room and board are
309.13 covered by medical assistance or state funds. The recommendations must be provided to
309.14 the legislative committees and divisions with jurisdiction over health and human services
309.15 policy and finance by February 1, 2014.

309.16 Sec. 58. **NURSING HOME LEVEL OF CARE REPORT.**

309.17 (a) The commissioner of human services shall report on the impact of the
309.18 modification to the nursing facility level of care to be implemented January 1, 2014,
309.19 including the following:

309.20 (1) the number of individuals who lose eligibility for home and community-based
309.21 services waivers under Minnesota Statutes, sections 256B.0915 and 256B.49, and
309.22 alternative care under Minnesota Statutes, section 256B.0913;

309.23 (2) the number of individuals who lose eligibility for medical assistance; and

309.24 (3) for individuals reported under clauses (1) and (2), and to the extent possible:

309.25 (i) their living situation before and after nursing facility level of care implementation;

309.26 and

309.27 (ii) the programs or services they received before and after nursing facility level of
309.28 care implementation, including, but not limited to, personal care assistant services and
309.29 essential community supports.

309.30 (b) The commissioner of human services shall report to the chairs and ranking
309.31 minority members of the legislative committees and divisions with jurisdiction over health
309.32 and human services policy and finance with the information required under paragraph

309.33 (a). A preliminary report shall be submitted on October 1, 2014, and a final report shall
309.34 be submitted February 15, 2015.

310.1 Sec. 59. **ASSISTIVE TECHNOLOGY EQUIPMENT FOR HOME AND**
310.2 **COMMUNITY-BASED SERVICES WAIVERS FUNDING DEVELOPMENT.**

310.3 (a) For the purposes of this section, "assistive technology equipment" includes
310.4 computer tablets, passive sensors, and other forms of technology allowing increased
310.5 safety and independence, and used by those receiving services through a home and
310.6 community-based services waiver under Minnesota Statutes, sections 256B.0915,
310.7 256B.092, and 256B.49.

310.8 (b) The commissioner of human services shall develop recommendations for
310.9 assistive technology equipment funding to enable individuals receiving services identified
310.10 in paragraph (a) to live in the least restrictive setting possible. In developing the funding,
310.11 the commissioner shall examine funding for the following:

310.12 (1) an assessment process to match the appropriate assistive technology equipment
310.13 with the waiver recipient, including when the recipient's condition changes or progresses;

310.14 (2) the use of monitoring services, if applicable, to the assistive technology
310.15 equipment identified in clause (1);

310.16 (3) the leasing of assistive technology equipment as a possible alternative to
310.17 purchasing the equipment; and

310.18 (4) ongoing support services, such as technological support.

310.19 (c) The commissioner shall provide the chairs and ranking minority members of the
310.20 legislative committees and divisions with jurisdiction over health and human services
310.21 policy and finance a recommendation for implementing an assistive technology equipment
310.22 program as developed in paragraph (b) by February 1, 2014.

310.23 Sec. 60. **PROVIDER RATE AND GRANT INCREASE EFFECTIVE APRIL**
310.24 **1, 2014.**

310.25 (a) The commissioner of human services shall increase reimbursement rates, grants,
310.26 allocations, individual limits, and rate limits, as applicable, by one percent for the rate
310.27 period beginning April 1, 2014, for services rendered on or after those dates. County or
310.28 tribal contracts for services specified in this section must be amended to pass through
310.29 these rate increases within 60 days of the effective date.

310.30 (b) The rate changes described in this section must be provided to:

310.31 (1) home and community-based waived services for persons with developmental
310.32 disabilities or related conditions, including consumer-directed community supports, under
310.33 Minnesota Statutes, section 256B.501;

- 311.1 (2) waived services under community alternatives for disabled individuals,
311.2 including consumer-directed community supports, under Minnesota Statutes, section
311.3 256B.49;
- 311.4 (3) community alternative care waived services, including consumer-directed
311.5 community supports, under Minnesota Statutes, section 256B.49;
- 311.6 (4) brain injury waived services, including consumer-directed community
311.7 supports, under Minnesota Statutes, section 256B.49;
- 311.8 (5) home and community-based waived services for the elderly under Minnesota
311.9 Statutes, section 256B.0915;
- 311.10 (6) nursing services and home health services under Minnesota Statutes, section
311.11 256B.0625, subdivision 6a;
- 311.12 (7) personal care services and qualified professional supervision of personal care
311.13 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;
- 311.14 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
311.15 subdivision 7;
- 311.16 (9) day training and habilitation services for adults with developmental disabilities
311.17 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
311.18 additional cost of rate adjustments on day training and habilitation services, provided as a
311.19 social service, formerly funded under Minnesota Statutes 2010, chapter 256M;
- 311.20 (10) alternative care services under Minnesota Statutes, section 256B.0913;
- 311.21 (11) living skills training programs for persons with intractable epilepsy who need
311.22 assistance in the transition to independent living under Laws 1988, chapter 689;
- 311.23 (12) semi-independent living services (SILS) under Minnesota Statutes, section
311.24 252.275, including SILS funding under county social services grants formerly funded
311.25 under Minnesota Statutes, chapter 256M;
- 311.26 (13) consumer support grants under Minnesota Statutes, section 256.476;
- 311.27 (14) family support grants under Minnesota Statutes, section 252.32;
- 311.28 (15) housing access grants under Minnesota Statutes, sections 256B.0658 and
311.29 256B.0917, subdivision 14;
- 311.30 (16) self-advocacy grants under Laws 2009, chapter 101;
- 311.31 (17) technology grants under Laws 2009, chapter 79;
- 311.32 (18) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
311.33 and 256B.0928; and
- 311.34 (19) community support services for deaf and hard-of-hearing adults with mental
311.35 illness who use or wish to use sign language as their primary means of communication
311.36 under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing

312.1 grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9;
312.2 and Laws 1997, First Special Session chapter 5, section 20.

312.3 (c) A managed care plan receiving state payments for the services in this section
312.4 must include these increases in their payments to providers. To implement the rate increase
312.5 in this section, capitation rates paid by the commissioner to managed care organizations
312.6 under Minnesota Statutes, section 256B.69, shall reflect a one percent increase for the
312.7 specified services for the period beginning April 1, 2014.

312.8 (d) Counties shall increase the budget for each recipient of consumer-directed
312.9 community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

312.10 **Sec. 61. SAFETY NET FOR HOME AND COMMUNITY-BASED SERVICES**
312.11 **WAIVERS.**

312.12 The commissioner of human services shall submit a request by December 31, 2013,
312.13 to the federal government to amend the home and community-based services waivers for
312.14 individuals with disabilities authorized under Minnesota Statutes, section 256B.49, to
312.15 modify the financial management of the home and community-based services waivers
312.16 to provide a state-administered safety net when costs for an individual increase above
312.17 an identified threshold. The implementation of the safety net may result in a decreased
312.18 allocation for individual counties, tribes, or collaboratives of counties or tribes, but must
312.19 not result in a net decreased statewide allocation.

312.20 **Sec. 62. SHARED LIVING MODEL.**

312.21 The commissioner of human services shall develop and promote a shared living model
312.22 option for individuals receiving services through the home and community-based services
312.23 wavers for individuals with disabilities, authorized under Minnesota Statutes, section
312.24 256B.092 or 256B.49, as an option for individuals who require 24-hour assistance. The
312.25 option must be a companion model with a limit of one or two individuals receiving support
312.26 in the home, planned respite for the caregiver, and the availability of intensive training
312.27 and support on the needs of the individual or individuals. Any necessary amendments to
312.28 implement the model must be submitted to the federal government by December 31, 2013.

312.29 **Sec. 63. MONEY FOLLOWS THE PERSON GRANT.**

312.30 The commissioner of human services shall submit to the federal government all
312.31 necessary waiver amendments to implement the Money Follows the Person federal grant
312.32 by December 31, 2013.

313.1 Sec. 64. **REPEALER.**

313.2 Minnesota Statutes 2012, sections 256B.0917, subdivision 14; 256B.096,
313.3 subdivisions 1, 2, 3, and 4; 256B.14, subdivision 3a; and 256B.5012, subdivision 13, and
313.4 Laws 2011, First Special Session chapter 9, article 7, section 54, as amended by Laws 2012,
313.5 chapter 247, article 4, section 42, and Laws 2012, chapter 298, section 3, are repealed.

313.6 **ARTICLE 8**

313.7 **WAIVER PROVIDER STANDARDS**

313.8 Section 1. Minnesota Statutes 2012, section 13.461, is amended by adding a
313.9 subdivision to read:

313.10 Subd. 7c. **Human services license holders.** Section 245D.095, subdivision 3,
313.11 requires certain license holders to protect service recipient records in accordance with
313.12 specified provisions of this chapter.

313.13 Sec. 2. Minnesota Statutes 2012, section 145C.01, subdivision 7, is amended to read:

313.14 Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity
313.15 licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under
313.16 section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47,
313.17 an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts
313.18 9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or
313.19 a hospice provider licensed under sections 144A.75 to 144A.755.

313.20 Sec. 3. Minnesota Statutes 2012, section 243.166, subdivision 4b, is amended to read:

313.21 Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this
313.22 subdivision, "health care facility" means a facility:

313.23 (1) licensed by the commissioner of health as a hospital, boarding care home or
313.24 supervised living facility under sections 144.50 to 144.58, or a nursing home under
313.25 chapter 144A;

313.26 (2) registered by the commissioner of health as a housing with services establishment
313.27 as defined in section 144D.01; or

313.28 (3) licensed by the commissioner of human services as a residential facility under
313.29 chapter 245A to provide adult foster care, adult mental health treatment, chemical
313.30 dependency treatment to adults, or residential services to persons with ~~developmental~~
313.31 disabilities.

313.32 (b) Prior to admission to a health care facility, a person required to register under
313.33 this section shall disclose to:

314.1 (1) the health care facility employee processing the admission the person's status
314.2 as a registered predatory offender under this section; and

314.3 (2) the person's corrections agent, or if the person does not have an assigned
314.4 corrections agent, the law enforcement authority with whom the person is currently
314.5 required to register, that inpatient admission will occur.

314.6 (c) A law enforcement authority or corrections agent who receives notice under
314.7 paragraph (b) or who knows that a person required to register under this section is
314.8 planning to be admitted and receive, or has been admitted and is receiving health care
314.9 at a health care facility shall notify the administrator of the facility and deliver a fact
314.10 sheet to the administrator containing the following information: (1) name and physical
314.11 description of the offender; (2) the offender's conviction history, including the dates of
314.12 conviction; (3) the risk level classification assigned to the offender under section 244.052,
314.13 if any; and (4) the profile of likely victims.

314.14 (d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care
314.15 facility receives a fact sheet under paragraph (c) that includes a risk level classification for
314.16 the offender, and if the facility admits the offender, the facility shall distribute the fact
314.17 sheet to all residents at the facility. If the facility determines that distribution to a resident
314.18 is not appropriate given the resident's medical, emotional, or mental status, the facility
314.19 shall distribute the fact sheet to the patient's next of kin or emergency contact.

314.20 Sec. 4. **[245.8251] POSITIVE SUPPORT STRATEGIES AND EMERGENCY**
314.21 **MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.**

314.22 Subdivision 1. Rules. The commissioner of human services shall, within 24 months
314.23 of enactment of this section, adopt rules governing the use of positive support strategies,
314.24 safety interventions, and emergency use of manual restraint in facilities and services
314.25 licensed under chapter 245D.

314.26 Subd. 2. Data collection. (a) The commissioner shall, with stakeholder input,
314.27 develop data collection elements specific to incidents of emergency use of manual restraint
314.28 and positive support transition plans for persons receiving services from providers
314.29 governed under chapter 245D effective January 1, 2014. Providers shall report the data in
314.30 a format and at a frequency determined by the commissioner of human services. Providers
314.31 shall submit the data to the commissioner and the Office of the Ombudsman for Mental
314.32 Health and Developmental Disabilities.

314.33 (b) Beginning July 1, 2013, providers regulated under Minnesota Rules, parts
314.34 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures
314.35 identified in Minnesota Rules, part 9525.2740, in a format and at a frequency determined

315.1 by the commissioner. Providers shall submit the data to the commissioner and the Office
315.2 of the Ombudsman for Mental Health and Developmental Disabilities.

315.3 Sec. 5. Minnesota Statutes 2012, section 245.91, is amended by adding a subdivision
315.4 to read:

315.5 Subd. 3a. **Emergency use of manual restraint.** "Emergency use of manual
315.6 restraint" has the meaning given in section 245D.02, subdivision 8a, and applies to
315.7 services licensed under chapter 245D.

315.8 Sec. 6. Minnesota Statutes 2012, section 245.94, subdivision 2, is amended to read:

315.9 Subd. 2. **Matters appropriate for review.** (a) In selecting matters for review by the
315.10 office, the ombudsman shall give particular attention to unusual deaths or injuries of a
315.11 client or reports of emergency use of manual restraint as identified in section 245D.061,
315.12 served by an agency, facility, or program, or actions of an agency, facility, or program that:

315.13 (1) may be contrary to law or rule;

315.14 (2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of
315.15 an agency, facility, or program;

315.16 (3) may be mistaken in law or arbitrary in the ascertainment of facts;

315.17 (4) may be unclear or inadequately explained, when reasons should have been
315.18 revealed;

315.19 (5) may result in abuse or neglect of a person receiving treatment;

315.20 (6) may disregard the rights of a client or other individual served by an agency
315.21 or facility;

315.22 (7) may impede or promote independence, community integration, and productivity
315.23 for clients; or

315.24 (8) may impede or improve the monitoring or evaluation of services provided to
315.25 clients.

315.26 (b) The ombudsman shall, in selecting matters for review and in the course of the
315.27 review, avoid duplicating other investigations or regulatory efforts.

315.28 Sec. 7. Minnesota Statutes 2012, section 245.94, subdivision 2a, is amended to read:

315.29 Subd. 2a. **Mandatory reporting.** Within 24 hours after a client suffers death or
315.30 serious injury, the agency, facility, or program director shall notify the ombudsman of the
315.31 death or serious injury. The emergency use of manual restraint must be reported to the
315.32 ombudsman as required under section 245D.061, subdivision 10. The ombudsman is

316.1 authorized to receive identifying information about a deceased client according to Code of
316.2 Federal Regulations, title 42, section 2.15, paragraph (b).

316.3 Sec. 8. Minnesota Statutes 2012, section 245A.02, subdivision 10, is amended to read:

316.4 Subd. 10. **Nonresidential program.** "Nonresidential program" means care,
316.5 supervision, rehabilitation, training or habilitation of a person provided outside the
316.6 person's own home and provided for fewer than 24 hours a day, including adult day
316.7 care programs; and chemical dependency or chemical abuse programs that are located
316.8 in a nursing home or hospital and receive public funds for providing chemical abuse or
316.9 chemical dependency treatment services under chapter 254B. Nonresidential programs
316.10 include home and community-based services ~~and semi-independent living services~~ for
316.11 persons with ~~developmental~~ disabilities or persons age 65 and older that are provided in
316.12 or outside of a person's own home under chapter 245D.

316.13 Sec. 9. Minnesota Statutes 2012, section 245A.02, subdivision 14, is amended to read:

316.14 Subd. 14. **Residential program.** "Residential program" means a program
316.15 that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training,
316.16 education, habilitation, or treatment outside a person's own home, including a program
316.17 in an intermediate care facility for four or more persons with developmental disabilities;
316.18 and chemical dependency or chemical abuse programs that are located in a hospital
316.19 or nursing home and receive public funds for providing chemical abuse or chemical
316.20 dependency treatment services under chapter 254B. Residential programs include home
316.21 and community-based services for persons with ~~developmental~~ disabilities or persons age
316.22 65 and older that are provided in or outside of a person's own home under chapter 245D.

316.23 Sec. 10. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

316.24 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial
316.25 license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340,
316.26 or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under
316.27 this chapter for a physical location that will not be the primary residence of the license
316.28 holder for the entire period of licensure. If a license is issued during this moratorium, and
316.29 the license holder changes the license holder's primary residence away from the physical
316.30 location of the foster care license, the commissioner shall revoke the license according
316.31 to section 245A.07. The commissioner shall not issue an initial license for a community
316.32 residential setting licensed under chapter 245D. Exceptions to the moratorium include:

316.33 (1) foster care settings that are required to be registered under chapter 144D;

317.1 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
317.2 community residential setting licenses replacing adult foster care licenses in existence on
317.3 December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

317.4 (3) new foster care licenses or community residential setting licenses determined to
317.5 be needed by the commissioner under paragraph (b) for the closure of a nursing facility,
317.6 ICF/MR, or regional treatment center, or restructuring of state-operated services that
317.7 limits the capacity of state-operated facilities;

317.8 (4) new foster care licenses or community residential setting licenses determined
317.9 to be needed by the commissioner under paragraph (b) for persons requiring hospital
317.10 level care; or

317.11 (5) new foster care licenses or community residential setting licenses determined to
317.12 be needed by the commissioner for the transition of people from personal care assistance
317.13 to the home and community-based services.

317.14 (b) The commissioner shall determine the need for newly licensed foster care
317.15 homes or community residential settings as defined under this subdivision. As part of the
317.16 determination, the commissioner shall consider the availability of foster care capacity in
317.17 the area in which the licensee seeks to operate, and the recommendation of the local
317.18 county board. The determination by the commissioner must be final. A determination of
317.19 need is not required for a change in ownership at the same address.

317.20 (c) The commissioner shall study the effects of the license moratorium under this
317.21 subdivision and shall report back to the legislature by January 15, 2011. This study shall
317.22 include, but is not limited to the following:

317.23 (1) the overall capacity and utilization of foster care beds where the physical location
317.24 is not the primary residence of the license holder prior to and after implementation
317.25 of the moratorium;

317.26 (2) the overall capacity and utilization of foster care beds where the physical
317.27 location is the primary residence of the license holder prior to and after implementation
317.28 of the moratorium; and

317.29 (3) the number of licensed and occupied ICF/MR beds prior to and after
317.30 implementation of the moratorium.

317.31 (d) When a ~~foster care recipient~~ an adult resident served by the program moves out
317.32 of a foster home that is not the primary residence of the license holder according to section
317.33 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the
317.34 county shall immediately inform the Department of Human Services Licensing Division.
317.35 The department shall decrease the statewide licensed capacity for adult foster care settings
317.36 where the physical location is not the primary residence of the license holder, or for adult

318.1 community residential settings, if the voluntary changes described in paragraph (f) are
318.2 not sufficient to meet the savings required by reductions in licensed bed capacity under
318.3 Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f),
318.4 and maintain statewide long-term care residential services capacity within budgetary
318.5 limits. Implementation of the statewide licensed capacity reduction shall begin on July
318.6 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the
318.7 needs determination process. Under this paragraph, the commissioner has the authority
318.8 to reduce unused licensed capacity of a current foster care program, or the community
318.9 residential settings, to accomplish the consolidation or closure of settings. A decreased
318.10 licensed capacity according to this paragraph is not subject to appeal under this chapter.

318.11 (e) Residential settings that would otherwise be subject to the decreased license
318.12 capacity established in paragraph (d) shall be exempt under the following circumstances:

318.13 (1) until August 1, 2013, the license holder's beds occupied by residents whose
318.14 primary diagnosis is mental illness and the license holder is:

318.15 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
318.16 health services (ARMHS) as defined in section 256B.0623;

318.17 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
318.18 9520.0870;

318.19 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
318.20 9520.0870; or

318.21 (iv) a provider of intensive residential treatment services (IRTS) licensed under
318.22 Minnesota Rules, parts 9520.0500 to 9520.0670; or

318.23 (2) the license holder is certified under the requirements in subdivision 6a or section
318.24 245D.33.

318.25 (f) A resource need determination process, managed at the state level, using the
318.26 available reports required by section 144A.351, and other data and information shall
318.27 be used to determine where the reduced capacity required under paragraph (d) will be
318.28 implemented. The commissioner shall consult with the stakeholders described in section
318.29 144A.351, and employ a variety of methods to improve the state's capacity to meet
318.30 long-term care service needs within budgetary limits, including seeking proposals from
318.31 service providers or lead agencies to change service type, capacity, or location to improve
318.32 services, increase the independence of residents, and better meet needs identified by the
318.33 long-term care services reports and statewide data and information. By February 1 of each
318.34 year, the commissioner shall provide information and data on the overall capacity of
318.35 licensed long-term care services, actions taken under this subdivision to manage statewide

319.1 long-term care services and supports resources, and any recommendations for change to
319.2 the legislative committees with jurisdiction over health and human services budget.

319.3 (g) At the time of application and reapplication for licensure, the applicant and the
319.4 license holder that are subject to the moratorium or an exclusion established in paragraph
319.5 (a) are required to inform the commissioner whether the physical location where the foster
319.6 care will be provided is or will be the primary residence of the license holder for the entire
319.7 period of licensure. If the primary residence of the applicant or license holder changes, the
319.8 applicant or license holder must notify the commissioner immediately. The commissioner
319.9 shall print on the foster care license certificate whether or not the physical location is the
319.10 primary residence of the license holder.

319.11 (h) License holders of foster care homes identified under paragraph (g) that are not
319.12 the primary residence of the license holder and that also provide services in the foster care
319.13 home that are covered by a federally approved home and community-based services
319.14 waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the
319.15 human services licensing division that the license holder provides or intends to provide
319.16 these waiver-funded services. ~~These license holders must be considered registered under~~
319.17 ~~section 256B.092, subdivision 11, paragraph (c), and this registration status must be~~
319.18 ~~identified on their license certificates.~~

319.19 Sec. 11. Minnesota Statutes 2012, section 245A.03, subdivision 8, is amended to read:

319.20 Subd. 8. **Excluded providers seeking licensure.** Nothing in this section shall
319.21 prohibit a program that is excluded from licensure under subdivision 2, paragraph
319.22 (a), clause ~~(28)~~ (26), from seeking licensure. The commissioner shall ensure that any
319.23 application received from such an excluded provider is processed in the same manner as
319.24 all other applications for child care center licensure.

319.25 Sec. 12. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

319.26 Subd. 9. **Permitted services by an individual who is related.** Notwithstanding
319.27 subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a
319.28 person receiving supported living services may provide licensed services to that person if:

319.29 (1) the person who receives supported living services received these services in a
319.30 residential site on July 1, 2005;

319.31 (2) the services under clause (1) were provided in a corporate foster care setting for
319.32 adults and were funded by the developmental disabilities home and community-based
319.33 services waiver defined in section 256B.092;

320.1 (3) the individual who is related obtains and maintains both a license under chapter
320.2 245B or successor licensing requirements for the provision of supported living services
320.3 and an adult foster care license under Minnesota Rules, parts 9555.5105 to 9555.6265; and

320.4 (4) the individual who is related is not the guardian of the person receiving supported
320.5 living services.

320.6 Sec. 13. Minnesota Statutes 2012, section 245A.042, subdivision 3, is amended to read:

320.7 Subd. 3. **Implementation.** (a) The commissioner shall implement the
320.8 responsibilities of this chapter according to the timelines in paragraphs (b) and (c)
320.9 only within the limits of available appropriations or other administrative cost recovery
320.10 methodology.

320.11 (b) The licensure of home and community-based services according to this section
320.12 shall be implemented January 1, 2014. License applications shall be received and
320.13 processed on a phased-in schedule as determined by the commissioner beginning July
320.14 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that
320.15 the application is complete according to section 245A.04.

320.16 (c) Within the limits of available appropriations or other administrative cost recovery
320.17 methodology, implementation of compliance monitoring must be phased in after January
320.18 1, 2014.

320.19 (1) Applicants who do not currently hold a license issued under ~~this~~ chapter 245B
320.20 must receive an initial compliance monitoring visit after 12 months of the effective date of
320.21 the initial license for the purpose of providing technical assistance on how to achieve and
320.22 maintain compliance with the applicable law or rules governing the provision of home and
320.23 community-based services under chapter 245D. If during the review the commissioner
320.24 finds that the license holder has failed to achieve compliance with an applicable law or
320.25 rule and this failure does not imminently endanger the health, safety, or rights of the
320.26 persons served by the program, the commissioner may issue a licensing review report with
320.27 recommendations for achieving and maintaining compliance.

320.28 (2) Applicants who do currently hold a license issued under this chapter must receive
320.29 a compliance monitoring visit after 24 months of the effective date of the initial license.

320.30 (d) Nothing in this subdivision shall be construed to limit the commissioner's
320.31 authority to suspend or revoke a license or issue a fine at any time under section 245A.07,
320.32 or ~~make issue~~ make issue correction orders and make a license conditional for failure to comply with
320.33 applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity
320.34 of the violation of law or rule and the effect of the violation on the health, safety, or
320.35 rights of persons served by the program.

321.1 Sec. 14. Minnesota Statutes 2012, section 245A.08, subdivision 2a, is amended to read:

321.2 Subd. 2a. **Consolidated contested case hearings.** (a) When a denial of a license
321.3 under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is
321.4 based on a disqualification for which reconsideration was requested and which was not
321.5 set aside under section 245C.22, the scope of the contested case hearing shall include the
321.6 disqualification and the licensing sanction or denial of a license, unless otherwise specified
321.7 in this subdivision. When the licensing sanction or denial of a license is based on a
321.8 determination of maltreatment under section 626.556 or 626.557, or a disqualification for
321.9 serious or recurring maltreatment which was not set aside, the scope of the contested case
321.10 hearing shall include the maltreatment determination, disqualification, and the licensing
321.11 sanction or denial of a license, unless otherwise specified in this subdivision. In such
321.12 cases, a fair hearing under section 256.045 shall not be conducted as provided for in
321.13 sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

321.14 (b) Except for family child care and child foster care, reconsideration of a
321.15 maltreatment determination under sections 626.556, subdivision 10i, and 626.557,
321.16 subdivision 9d, and reconsideration of a disqualification under section 245C.22, shall
321.17 not be conducted when:

321.18 (1) a denial of a license under section 245A.05, or a licensing sanction under section
321.19 245A.07, is based on a determination that the license holder is responsible for maltreatment
321.20 or the disqualification of a license holder is based on serious or recurring maltreatment;

321.21 (2) the denial of a license or licensing sanction is issued at the same time as the
321.22 maltreatment determination or disqualification; and

321.23 (3) the license holder appeals the maltreatment determination or disqualification,
321.24 and denial of a license or licensing sanction. In these cases, a fair hearing shall not be
321.25 conducted under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision
321.26 9d. The scope of the contested case hearing must include the maltreatment determination,
321.27 disqualification, and denial of a license or licensing sanction.

321.28 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
321.29 determination or disqualification, but does not appeal the denial of a license or a licensing
321.30 sanction, reconsideration of the maltreatment determination shall be conducted under
321.31 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
321.32 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
321.33 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
321.34 626.557, subdivision 9d.

321.35 (c) In consolidated contested case hearings regarding sanctions issued in family child
321.36 care, child foster care, family adult day services, ~~and adult foster care,~~ and community

322.1 residential settings, the county attorney shall defend the commissioner's orders in
322.2 accordance with section 245A.16, subdivision 4.

322.3 (d) The commissioner's final order under subdivision 5 is the final agency action
322.4 on the issue of maltreatment and disqualification, including for purposes of subsequent
322.5 background studies under chapter 245C and is the only administrative appeal of the final
322.6 agency determination, specifically, including a challenge to the accuracy and completeness
322.7 of data under section 13.04.

322.8 (e) When consolidated hearings under this subdivision involve a licensing sanction
322.9 based on a previous maltreatment determination for which the commissioner has issued
322.10 a final order in an appeal of that determination under section 256.045, or the individual
322.11 failed to exercise the right to appeal the previous maltreatment determination under
322.12 section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is
322.13 conclusive on the issue of maltreatment. In such cases, the scope of the administrative
322.14 law judge's review shall be limited to the disqualification and the licensing sanction or
322.15 denial of a license. In the case of a denial of a license or a licensing sanction issued to
322.16 a facility based on a maltreatment determination regarding an individual who is not the
322.17 license holder or a household member, the scope of the administrative law judge's review
322.18 includes the maltreatment determination.

322.19 (f) The hearings of all parties may be consolidated into a single contested case
322.20 hearing upon consent of all parties and the administrative law judge, if:

322.21 (1) a maltreatment determination or disqualification, which was not set aside under
322.22 section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing
322.23 sanction under section 245A.07;

322.24 (2) the disqualified subject is an individual other than the license holder and upon
322.25 whom a background study must be conducted under section 245C.03; and

322.26 (3) the individual has a hearing right under section 245C.27.

322.27 (g) When a denial of a license under section 245A.05 or a licensing sanction under
322.28 section 245A.07 is based on a disqualification for which reconsideration was requested
322.29 and was not set aside under section 245C.22, and the individual otherwise has no hearing
322.30 right under section 245C.27, the scope of the administrative law judge's review shall
322.31 include the denial or sanction and a determination whether the disqualification should
322.32 be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In
322.33 determining whether the disqualification should be set aside, the administrative law judge
322.34 shall consider the factors under section 245C.22, subdivision 4, to determine whether the
322.35 individual poses a risk of harm to any person receiving services from the license holder.

323.1 (h) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction
323.2 under section 245A.07 is based on the termination of a variance under section 245C.30,
323.3 subdivision 4, the scope of the administrative law judge's review shall include the sanction
323.4 and a determination whether the disqualification should be set aside, unless section
323.5 245C.24 prohibits the set-aside of the disqualification. In determining whether the
323.6 disqualification should be set aside, the administrative law judge shall consider the factors
323.7 under section 245C.22, subdivision 4, to determine whether the individual poses a risk of
323.8 harm to any person receiving services from the license holder.

323.9 Sec. 15. Minnesota Statutes 2012, section 245A.10, is amended to read:

323.10 **245A.10 FEES.**

323.11 Subdivision 1. **Application or license fee required, programs exempt from fee.**

323.12 (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation
323.13 of applications and inspection of programs which are licensed under this chapter.

323.14 (b) Except as provided under subdivision 2, no application or license fee shall be
323.15 charged for child foster care, adult foster care, ~~or~~ family and group family child care, or
323.16 a community residential setting.

323.17 Subd. 2. **County fees for background studies and licensing inspections.** (a) For
323.18 purposes of family and group family child care licensing under this chapter, a county
323.19 agency may charge a fee to an applicant or license holder to recover the actual cost of
323.20 background studies, but in any case not to exceed \$100 annually. A county agency may
323.21 also charge a license fee to an applicant or license holder not to exceed \$50 for a one-year
323.22 license or \$100 for a two-year license.

323.23 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
323.24 applicant for authorization to recover the actual cost of background studies completed
323.25 under section 119B.125, but in any case not to exceed \$100 annually.

323.26 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

323.27 (1) in cases of financial hardship;

323.28 (2) if the county has a shortage of providers in the county's area;

323.29 (3) for new providers; or

323.30 (4) for providers who have attained at least 16 hours of training before seeking
323.31 initial licensure.

323.32 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
323.33 an installment basis for up to one year. If the provider is receiving child care assistance
323.34 payments from the state, the provider may have the fees under paragraph (a) or (b)

324.1 deducted from the child care assistance payments for up to one year and the state shall
324.2 reimburse the county for the county fees collected in this manner.

324.3 (e) For purposes of adult foster care and child foster care licensing, and licensing
324.4 the physical plant of a community residential setting, under this chapter, a county agency
324.5 may charge a fee to a corporate applicant or corporate license holder to recover the actual
324.6 cost of licensing inspections, not to exceed \$500 annually.

324.7 (f) Counties may elect to reduce or waive the fees in paragraph (e) under the
324.8 following circumstances:

324.9 (1) in cases of financial hardship;

324.10 (2) if the county has a shortage of providers in the county's area; or

324.11 (3) for new providers.

324.12 Subd. 3. **Application fee for initial license or certification.** (a) For fees required
324.13 under subdivision 1, an applicant for an initial license or certification issued by the
324.14 commissioner shall submit a \$500 application fee with each new application required
324.15 under this subdivision. An applicant for an initial day services facility license under
324.16 chapter 245D shall submit a \$250 application fee with each new application. The
324.17 application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license
324.18 or certification fee that expires on December 31. The commissioner shall not process an
324.19 application until the application fee is paid.

324.20 (b) Except as provided in clauses (1) to ~~(4)~~ (3), an applicant shall apply for a license
324.21 to provide services at a specific location.

324.22 ~~(1) For a license to provide residential-based habilitation services to persons with~~
324.23 ~~developmental disabilities under chapter 245B, an applicant shall submit an application~~
324.24 ~~for each county in which the services will be provided. Upon licensure, the license~~
324.25 ~~holder may provide services to persons in that county plus no more than three persons~~
324.26 ~~at any one time in each of up to ten additional counties. A license holder in one county~~
324.27 ~~may not provide services under the home and community-based waiver for persons with~~
324.28 ~~developmental disabilities to more than three people in a second county without holding~~
324.29 ~~a separate license for that second county. Applicants or licensees providing services~~
324.30 ~~under this clause to not more than three persons remain subject to the inspection fees~~
324.31 ~~established in section 245A.10, subdivision 2, for each location. The license issued by~~
324.32 ~~the commissioner must state the name of each additional county where services are being~~
324.33 ~~provided to persons with developmental disabilities. A license holder must notify the~~
324.34 ~~commissioner before making any changes that would alter the license information listed~~
324.35 ~~under section 245A.04, subdivision 7, paragraph (a), including any additional counties~~
324.36 ~~where persons with developmental disabilities are being served.~~ For a license to provide

325.1 home and community-based services to persons with disabilities or age 65 and older under
 325.2 chapter 245D, an applicant shall submit an application to provide services statewide.
 325.3 Notwithstanding paragraph (a), applications received by the commissioner between July 1,
 325.4 2013, and December 31, 2013, for licensure of services provided under chapter 245D must
 325.5 include an application fee that is equal to the annual license renewal fee under subdivision
 325.6 4, paragraph (b), or \$500, whichever is less. Applications received by the commissioner
 325.7 after January 1, 2014, must include the application fee required under paragraph (a).
 325.8 Applicants who meet the modified application criteria identified in section 245A.042,
 325.9 subdivision 2, are exempt from paying an application fee.

325.10 ~~(2) For a license to provide supported employment, crisis respite, or~~
 325.11 ~~semi-independent living services to persons with developmental disabilities under chapter~~
 325.12 ~~245B, an applicant shall submit a single application to provide services statewide.~~

325.13 ~~(3) For a license to provide independent living assistance for youth under section~~
 325.14 ~~245A.22, an applicant shall submit a single application to provide services statewide.~~

325.15 ~~(4)~~ (3) For a license for a private agency to provide foster care or adoption services
 325.16 under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single
 325.17 application to provide services statewide.

325.18 (c) The initial application fee charged under this subdivision does not include the
 325.19 temporary license surcharge under section 16E.22.

325.20 **Subd. 4. License or certification fee for certain programs.** (a) Child care centers
 325.21 shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	\$200
25 to 49 persons	\$300
50 to 74 persons	\$400
75 to 99 persons	\$500
100 to 124 persons	\$600
125 to 149 persons	\$700
150 to 174 persons	\$800
175 to 199 persons	\$900
200 to 224 persons	\$1,000
225 or more persons	\$1,100

325.34 ~~(b) A day training and habilitation program serving persons with developmental~~
 325.35 ~~disabilities or related conditions shall pay an annual nonrefundable license fee based on~~
 325.36 ~~the following schedule:~~

Licensed Capacity	License Fee
1 to 24 persons	\$800

326.1	25 to 49 persons	\$1,000
326.2	50 to 74 persons	\$1,200
326.3	75 to 99 persons	\$1,400
326.4	100 to 124 persons	\$1,600
326.5	125 to 149 persons	\$1,800
326.6	150 or more persons	\$2,000

326.7 ~~Except as provided in paragraph (c), when a day training and habilitation program~~
 326.8 ~~serves more than 50 percent of the same persons in two or more locations in a community,~~
 326.9 ~~the day training and habilitation program shall pay a license fee based on the licensed~~
 326.10 ~~capacity of the largest facility and the other facility or facilities shall be charged a license~~
 326.11 ~~fee based on a licensed capacity of a residential program serving one to 24 persons.~~

326.12 ~~(e) When a day training and habilitation program serving persons with developmental~~
 326.13 ~~disabilities or related conditions seeks a single license allowed under section 245B.07,~~
 326.14 ~~subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed~~
 326.15 ~~capacity for each location.~~

326.16 ~~(d) A program licensed to provide supported employment services to persons~~
 326.17 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
 326.18 ~~license fee of \$650.~~

326.19 ~~(e) A program licensed to provide crisis respite services to persons with~~
 326.20 ~~developmental disabilities under chapter 245B shall pay an annual nonrefundable license~~
 326.21 ~~fee of \$700.~~

326.22 ~~(f) A program licensed to provide semi-independent living services to persons~~
 326.23 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
 326.24 ~~license fee of \$700.~~

326.25 ~~(g) A program licensed to provide residential-based habilitation services under the~~
 326.26 ~~home and community-based waiver for persons with developmental disabilities shall pay~~
 326.27 ~~an annual license fee that includes a base rate of \$690 plus \$60 times the number of clients~~
 326.28 ~~served on the first day of July of the current license year.~~

326.29 ~~(h) A residential program certified by the Department of Health as an intermediate~~
 326.30 ~~care facility for persons with developmental disabilities (ICF/MR) and a noncertified~~
 326.31 ~~residential program licensed to provide health or rehabilitative services for persons~~
 326.32 ~~with developmental disabilities shall pay an annual nonrefundable license fee based on~~
 326.33 ~~the following schedule:~~

326.34	Licensed Capacity	License Fee
326.35	1 to 24 persons	\$535
326.36	25 to 49 persons	\$735
326.37	50 or more persons	\$935

327.1 (b)(1) A program licensed to provide one or more of the home and community-based
 327.2 services and supports identified under chapter 245D to persons with disabilities or age
 327.3 65 and older, shall pay an annual nonrefundable license fee based on revenues derived
 327.4 from the provision of services that would require licensure under chapter 245D during the
 327.5 calendar year immediately preceding the year in which the license fee is paid, according to
 327.6 the following schedule:

327.7	<u>License Holder Annual Revenue</u>	<u>License Fee</u>
327.8	<u>less than or equal to \$10,000</u>	<u>\$200</u>
327.9	<u>greater than \$10,000 but less than or equal</u>	
327.10	<u>to \$25,000</u>	<u>\$300</u>
327.11	<u>greater than \$25,000 but less than or equal</u>	
327.12	<u>to \$50,000</u>	<u>\$400</u>
327.13	<u>greater than \$50,000 but less than or equal</u>	
327.14	<u>to \$100,000</u>	<u>\$500</u>
327.15	<u>greater than \$100,000 but less than or equal</u>	
327.16	<u>to \$150,000</u>	<u>\$600</u>
327.17	<u>greater than \$150,000 but less than or equal</u>	
327.18	<u>to \$200,000</u>	<u>\$800</u>
327.19	<u>greater than \$200,000 but less than or equal</u>	
327.20	<u>to \$250,000</u>	<u>\$1,000</u>
327.21	<u>greater than \$250,000 but less than or equal</u>	
327.22	<u>to \$300,000</u>	<u>\$1,200</u>
327.23	<u>greater than \$300,000 but less than or equal</u>	
327.24	<u>to \$350,000</u>	<u>\$1,400</u>
327.25	<u>greater than \$350,000 but less than or equal</u>	
327.26	<u>to \$400,000</u>	<u>\$1,600</u>
327.27	<u>greater than \$400,000 but less than or equal</u>	
327.28	<u>to \$450,000</u>	<u>\$1,800</u>
327.29	<u>greater than \$450,000 but less than or equal</u>	
327.30	<u>to \$500,000</u>	<u>\$2,000</u>
327.31	<u>greater than \$500,000 but less than or equal</u>	
327.32	<u>to \$600,000</u>	<u>\$2,250</u>
327.33	<u>greater than \$600,000 but less than or equal</u>	
327.34	<u>to \$700,000</u>	<u>\$2,500</u>
327.35	<u>greater than \$700,000 but less than or equal</u>	
327.36	<u>to \$800,000</u>	<u>\$2,750</u>
327.37	<u>greater than \$800,000 but less than or equal</u>	
327.38	<u>to \$900,000</u>	<u>\$3,000</u>
327.39	<u>greater than \$900,000 but less than or equal</u>	
327.40	<u>to \$1,000,000</u>	<u>\$3,250</u>
327.41	<u>greater than \$1,000,000 but less than or</u>	
327.42	<u>equal to \$1,250,000</u>	<u>\$3,500</u>
327.43	<u>greater than \$1,250,000 but less than or</u>	
327.44	<u>equal to \$1,500,000</u>	<u>\$3,750</u>
327.45	<u>greater than \$1,500,000 but less than or</u>	
327.46	<u>equal to \$1,750,000</u>	<u>\$4,000</u>

328.1	<u>greater than \$1,750,000 but less than or</u>	
328.2	<u>equal to \$2,000,000</u>	<u>\$4,250</u>
328.3	<u>greater than \$2,000,000 but less than or</u>	
328.4	<u>equal to \$2,500,000</u>	<u>\$4,500</u>
328.5	<u>greater than \$2,500,000 but less than or</u>	
328.6	<u>equal to \$3,000,000</u>	<u>\$4,750</u>
328.7	<u>greater than \$3,000,000 but less than or</u>	
328.8	<u>equal to \$3,500,000</u>	<u>\$5,000</u>
328.9	<u>greater than \$3,500,000 but less than or</u>	
328.10	<u>equal to \$4,000,000</u>	<u>\$5,500</u>
328.11	<u>greater than \$4,000,000 but less than or</u>	
328.12	<u>equal to \$4,500,000</u>	<u>\$6,000</u>
328.13	<u>greater than \$4,500,000 but less than or</u>	
328.14	<u>equal to \$5,000,000</u>	<u>\$6,500</u>
328.15	<u>greater than \$5,000,000 but less than or</u>	
328.16	<u>equal to \$7,500,000</u>	<u>\$7,000</u>
328.17	<u>greater than \$7,500,000 but less than or</u>	
328.18	<u>equal to \$10,000,000</u>	<u>\$8,500</u>
328.19	<u>greater than \$10,000,000 but less than or</u>	
328.20	<u>equal to \$12,500,000</u>	<u>\$10,000</u>
328.21	<u>greater than \$12,500,000 but less than or</u>	
328.22	<u>equal to \$15,000,000</u>	<u>\$14,000</u>
328.23	<u>greater than \$15,000,000</u>	<u>\$18,000</u>

328.24 (2) If requested, the license holder shall provide the commissioner information to
 328.25 verify the license holder's annual revenues or other information as needed, including
 328.26 copies of documents submitted to the Department of Revenue.

328.27 (3) At each annual renewal, a license holder may elect to pay the highest renewal
 328.28 fee, and not provide annual revenue information to the commissioner.

328.29 (4) A license holder that knowingly provides the commissioner incorrect revenue
 328.30 amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in
 328.31 the amount of double the fee the provider should have paid.

328.32 (5) Notwithstanding clause (1), a license holder providing services under one or
 328.33 more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual
 328.34 license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid
 328.35 by the license holder for all licenses held under chapter 245B for calendar year 2013.
 328.36 For calendar year 2017 and thereafter, the license holder shall pay an annual license fee
 328.37 according to clause (1).

328.38 (†) (c) A chemical dependency treatment program licensed under Minnesota Rules,
 328.39 parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an
 328.40 annual nonrefundable license fee based on the following schedule:

328.41	Licensed Capacity	License Fee
328.42	1 to 24 persons	\$600

329.1	25 to 49 persons	\$800
329.2	50 to 74 persons	\$1,000
329.3	75 to 99 persons	\$1,200
329.4	100 or more persons	\$1,400

329.5 ~~(j)~~ (d) A chemical dependency program licensed under Minnesota Rules, parts
 329.6 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual
 329.7 nonrefundable license fee based on the following schedule:

	Licensed Capacity	License Fee
329.8	1 to 24 persons	\$760
329.9	25 to 49 persons	\$960
329.10	50 or more persons	\$1,160

329.12 ~~(k)~~ (e) Except for child foster care, a residential facility licensed under Minnesota
 329.13 Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee
 329.14 based on the following schedule:

	Licensed Capacity	License Fee
329.15	1 to 24 persons	\$1,000
329.16	25 to 49 persons	\$1,100
329.17	50 to 74 persons	\$1,200
329.18	75 to 99 persons	\$1,300
329.19	100 or more persons	\$1,400

329.21 ~~(l)~~ (f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to
 329.22 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license
 329.23 fee based on the following schedule:

	Licensed Capacity	License Fee
329.24	1 to 24 persons	\$2,525
329.25	25 or more persons	\$2,725

329.27 ~~(m)~~ (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to
 329.28 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
 329.29 license fee based on the following schedule:

	Licensed Capacity	License Fee
329.30	1 to 24 persons	\$450
329.31	25 to 49 persons	\$650
329.32	50 to 74 persons	\$850
329.33	75 to 99 persons	\$1,050
329.34	100 or more persons	\$1,250

329.36 ~~(n)~~ (h) A program licensed to provide independent living assistance for youth under
 329.37 section 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

330.1 ~~(h)~~ (i) A private agency licensed to provide foster care and adoption services under
 330.2 Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable
 330.3 license fee of \$875.

330.4 ~~(p)~~ (j) A program licensed as an adult day care center licensed under Minnesota
 330.5 Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based
 330.6 on the following schedule:

330.7	Licensed Capacity	License Fee
330.8	1 to 24 persons	\$500
330.9	25 to 49 persons	\$700
330.10	50 to 74 persons	\$900
330.11	75 to 99 persons	\$1,100
330.12	100 or more persons	\$1,300

330.13 ~~(q)~~ (k) A program licensed to provide treatment services to persons with sexual
 330.14 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts
 330.15 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

330.16 ~~(r)~~ (l) A mental health center or mental health clinic requesting certification for
 330.17 purposes of insurance and subscriber contract reimbursement under Minnesota Rules,
 330.18 parts 9520.0750 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the
 330.19 mental health center or mental health clinic provides services at a primary location with
 330.20 satellite facilities, the satellite facilities shall be certified with the primary location without
 330.21 an additional charge.

330.22 **Subd. 6. License not issued until license or certification fee is paid.** The
 330.23 commissioner shall not issue a license or certification until the license or certification fee
 330.24 is paid. The commissioner shall send a bill for the license or certification fee to the billing
 330.25 address identified by the license holder. If the license holder does not submit the license or
 330.26 certification fee payment by the due date, the commissioner shall send the license holder
 330.27 a past due notice. If the license holder fails to pay the license or certification fee by the
 330.28 due date on the past due notice, the commissioner shall send a final notice to the license
 330.29 holder informing the license holder that the program license will expire on December 31
 330.30 unless the license fee is paid before December 31. If a license expires, the program is no
 330.31 longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2,
 330.32 must not operate after the expiration date. After a license expires, if the former license
 330.33 holder wishes to provide licensed services, the former license holder must submit a new
 330.34 license application and application fee under subdivision 3.

330.35 **Subd. 7. Human services licensing fees to recover expenditures.** Notwithstanding
 330.36 section 16A.1285, subdivision 2, related to activities for which the commissioner charges
 330.37 a fee, the commissioner must plan to fully recover direct expenditures for licensing

331.1 activities under this chapter over a five-year period. The commissioner may have
331.2 anticipated expenditures in excess of anticipated revenues in a biennium by using surplus
331.3 revenues accumulated in previous bienniums.

331.4 Subd. 8. **Deposit of license fees.** A human services licensing account is created in
331.5 the state government special revenue fund. Fees collected under subdivisions 3 and 4 must
331.6 be deposited in the human services licensing account and are annually appropriated to the
331.7 commissioner for licensing activities authorized under this chapter.

331.8 **EFFECTIVE DATE.** This section is effective July 1, 2013.

331.9 Sec. 16. Minnesota Statutes 2012, section 245A.11, subdivision 2a, is amended to read:

331.10 Subd. 2a. **Adult foster care and community residential setting license capacity.**

331.11 (a) The commissioner shall issue adult foster care and community residential setting
331.12 licenses with a maximum licensed capacity of four beds, including nonstaff roomers and
331.13 boarders, except that the commissioner may issue a license with a capacity of five beds,
331.14 including roomers and boarders, according to paragraphs (b) to (f).

331.15 (b) ~~An adult foster care~~ The license holder may have a maximum license capacity
331.16 of five if all persons in care are age 55 or over and do not have a serious and persistent
331.17 mental illness or a developmental disability.

331.18 (c) The commissioner may grant variances to paragraph (b) to allow a ~~foster care~~
331.19 provider facility with a licensed capacity of five persons to admit an individual under the
331.20 age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of
331.21 the variance is recommended by the county in which the licensed ~~foster care provider~~
331.22 facility is located.

331.23 (d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth
331.24 bed for emergency crisis services for a person with serious and persistent mental illness
331.25 or a developmental disability, regardless of age, if the variance complies with section
331.26 245A.04, subdivision 9, and approval of the variance is recommended by the county in
331.27 which the licensed ~~foster care provider~~ facility is located.

331.28 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of a
331.29 fifth bed for respite services, as defined in section 245A.02, for persons with disabilities,
331.30 regardless of age, if the variance complies with sections 245A.03, subdivision 7, and
331.31 245A.04, subdivision 9, and approval of the variance is recommended by the county in
331.32 which the licensed ~~foster care provider~~ facility is ~~licensed~~ located. Respite care may be
331.33 provided under the following conditions:

331.34 (1) staffing ratios cannot be reduced below the approved level for the individuals
331.35 being served in the home on a permanent basis;

332.1 (2) no more than two different individuals can be accepted for respite services in
332.2 any calendar month and the total respite days may not exceed 120 days per program in
332.3 any calendar year;

332.4 (3) the person receiving respite services must have his or her own bedroom, which
332.5 could be used for alternative purposes when not used as a respite bedroom, and cannot be
332.6 the room of another person who lives in the ~~foster care home~~ facility; and

332.7 (4) individuals living in the ~~foster care home~~ facility must be notified when the
332.8 variance is approved. The provider must give 60 days' notice in writing to the residents
332.9 and their legal representatives prior to accepting the first respite placement. Notice must
332.10 be given to residents at least two days prior to service initiation, or as soon as the license
332.11 holder is able if they receive notice of the need for respite less than two days prior to
332.12 initiation, each time a respite client will be served, unless the requirement for this notice is
332.13 waived by the resident or legal guardian.

332.14 (f) The commissioner may issue an adult foster care or community residential setting
332.15 license with a capacity of five adults if the fifth bed does not increase the overall statewide
332.16 capacity of licensed adult foster care or community residential setting beds in homes that
332.17 are not the primary residence of the license holder, as identified in a plan submitted to the
332.18 commissioner by the county, when the capacity is recommended by the county licensing
332.19 agency of the county in which the facility is located and if the recommendation verifies that:

332.20 (1) the facility meets the physical environment requirements in the adult foster
332.21 care licensing rule;

332.22 (2) the five-bed living arrangement is specified for each resident in the resident's:

332.23 (i) individualized plan of care;

332.24 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

332.25 (iii) individual resident placement agreement under Minnesota Rules, part
332.26 9555.5105, subpart 19, if required;

332.27 (3) the license holder obtains written and signed informed consent from each
332.28 resident or resident's legal representative documenting the resident's informed choice
332.29 to remain living in the home and that the resident's refusal to consent would not have
332.30 resulted in service termination; and

332.31 (4) the facility was licensed for adult foster care before March 1, 2011.

332.32 (g) The commissioner shall not issue a new adult foster care license under paragraph
332.33 (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care
332.34 license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five
332.35 adults if the license holder continues to comply with the requirements in paragraph (f).

333.1 Sec. 17. Minnesota Statutes 2012, section 245A.11, subdivision 7, is amended to read:

333.2 Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The
333.3 commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts
333.4 requiring a caregiver to be present in an adult foster care home during normal sleeping
333.5 hours to allow for alternative methods of overnight supervision. The commissioner may
333.6 grant the variance if the local county licensing agency recommends the variance and the
333.7 county recommendation includes documentation verifying that:

333.8 (1) the county has approved the license holder's plan for alternative methods of
333.9 providing overnight supervision and determined the plan protects the residents' health,
333.10 safety, and rights;

333.11 (2) the license holder has obtained written and signed informed consent from
333.12 each resident or each resident's legal representative documenting the resident's or legal
333.13 representative's agreement with the alternative method of overnight supervision; and

333.14 (3) the alternative method of providing overnight supervision, which may include
333.15 the use of technology, is specified for each resident in the resident's: (i) individualized
333.16 plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if
333.17 required; or (iii) individual resident placement agreement under Minnesota Rules, part
333.18 9555.5105, subpart 19, if required.

333.19 (b) To be eligible for a variance under paragraph (a), the adult foster care license
333.20 holder must not have had a conditional license issued under section 245A.06, or any
333.21 other licensing sanction issued under section 245A.07 during the prior 24 months based
333.22 on failure to provide adequate supervision, health care services, or resident safety in
333.23 the adult foster care home.

333.24 (c) A license holder requesting a variance under this subdivision to utilize
333.25 technology as a component of a plan for alternative overnight supervision may request
333.26 the commissioner's review in the absence of a county recommendation. Upon receipt of
333.27 such a request from a license holder, the commissioner shall review the variance request
333.28 with the county.

333.29 (d) A variance granted by the commissioner according to this subdivision before
333.30 January 1, 2014, to a license holder for an adult foster care home must transfer with the
333.31 license when the license converts to a community residential setting license under chapter
333.32 245D. The terms and conditions of the variance remain in effect as approved at the time
333.33 the variance was granted.

333.34 Sec. 18. Minnesota Statutes 2012, section 245A.11, subdivision 7a, is amended to read:

334.1 Subd. 7a. **Alternate overnight supervision technology; adult foster care license**
334.2 **and community residential setting licenses.** (a) The commissioner may grant an
334.3 applicant or license holder an adult foster care or community residential setting license
334.4 for a residence that does not have a caregiver in the residence during normal sleeping
334.5 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section
334.6 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder
334.7 when an incident occurs that may jeopardize the health, safety, or rights of a foster
334.8 care recipient. The applicant or license holder must comply with all other requirements
334.9 under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under
334.10 chapter 245D, and the requirements under this subdivision. The license printed by the
334.11 commissioner must state in bold and large font:

334.12 (1) that the facility is under electronic monitoring; and

334.13 (2) the telephone number of the county's common entry point for making reports of
334.14 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

334.15 (b) Applications for a license under this section must be submitted directly to
334.16 the Department of Human Services licensing division. The licensing division must
334.17 immediately notify the ~~host county and lead county contract agency and the host county~~
334.18 licensing agency. The licensing division must collaborate with the county licensing
334.19 agency in the review of the application and the licensing of the program.

334.20 (c) Before a license is issued by the commissioner, and for the duration of the
334.21 license, the applicant or license holder must establish, maintain, and document the
334.22 implementation of written policies and procedures addressing the requirements in
334.23 paragraphs (d) through (f).

334.24 (d) The applicant or license holder must have policies and procedures that:

334.25 (1) establish characteristics of target populations that will be admitted into the home,
334.26 and characteristics of populations that will not be accepted into the home;

334.27 (2) explain the discharge process when a ~~foster care recipient~~ resident served by the
334.28 program requires overnight supervision or other services that cannot be provided by the
334.29 license holder due to the limited hours that the license holder is on site;

334.30 (3) describe the types of events to which the program will respond with a physical
334.31 presence when those events occur in the home during time when staff are not on site, and
334.32 how the license holder's response plan meets the requirements in paragraph (e), clause
334.33 (1) or (2);

334.34 (4) establish a process for documenting a review of the implementation and
334.35 effectiveness of the response protocol for the response required under paragraph (e),
334.36 clause (1) or (2). The documentation must include:

- 335.1 (i) a description of the triggering incident;
- 335.2 (ii) the date and time of the triggering incident;
- 335.3 (iii) the time of the response or responses under paragraph (e), clause (1) or (2);
- 335.4 (iv) whether the response met the resident's needs;
- 335.5 (v) whether the existing policies and response protocols were followed; and
- 335.6 (vi) whether the existing policies and protocols are adequate or need modification.

335.7 When no physical presence response is completed for a three-month period, the
335.8 license holder's written policies and procedures must require a physical presence response
335.9 drill to be conducted for which the effectiveness of the response protocol under paragraph
335.10 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

335.11 (5) establish that emergency and nonemergency phone numbers are posted in a
335.12 prominent location in a common area of the home where they can be easily observed by a
335.13 person responding to an incident who is not otherwise affiliated with the home.

335.14 (e) The license holder must document and include in the license application which
335.15 response alternative under clause (1) or (2) is in place for responding to situations that
335.16 present a serious risk to the health, safety, or rights of ~~people receiving foster care services~~
335.17 in the home residents served by the program:

335.18 (1) response alternative (1) requires only the technology to provide an electronic
335.19 notification or alert to the license holder that an event is underway that requires a response.
335.20 Under this alternative, no more than ten minutes will pass before the license holder will be
335.21 physically present on site to respond to the situation; or

335.22 (2) response alternative (2) requires the electronic notification and alert system under
335.23 alternative (1), but more than ten minutes may pass before the license holder is present on
335.24 site to respond to the situation. Under alternative (2), all of the following conditions are met:

335.25 (i) the license holder has a written description of the interactive technological
335.26 applications that will assist the license holder in communicating with and assessing the
335.27 needs related to the care, health, and safety of the foster care recipients. This interactive
335.28 technology must permit the license holder to remotely assess the well being of the ~~foster~~
335.29 care recipient resident served by the program without requiring the initiation of the
335.30 foster care recipient. Requiring the foster care recipient to initiate a telephone call does
335.31 not meet this requirement;

335.32 (ii) the license holder documents how the remote license holder is qualified and
335.33 capable of meeting the needs of the foster care recipients and assessing foster care
335.34 recipients' needs under item (i) during the absence of the license holder on site;

335.35 (iii) the license holder maintains written procedures to dispatch emergency response
335.36 personnel to the site in the event of an identified emergency; and

336.1 (iv) each ~~foster care recipient's~~ resident's individualized plan of care, ~~individual~~
336.2 ~~service plan~~ coordinated service and support plan under ~~section~~ sections 256B.0913,
336.3 subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49,
336.4 subdivision 15, if required, or individual resident placement agreement under Minnesota
336.5 Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time,
336.6 which may be greater than ten minutes, for the license holder to be on site for that ~~foster~~
336.7 ~~care recipient~~ resident.

336.8 (f) Each ~~foster care recipient's~~ resident's placement agreement, individual service
336.9 agreement, and plan must clearly state that the adult foster care or community residential
336.10 setting license category is a program without the presence of a caregiver in the residence
336.11 during normal sleeping hours; the protocols in place for responding to situations that
336.12 present a serious risk to the health, safety, or rights of ~~foster care recipients~~ residents
336.13 served by the program under paragraph (e), clause (1) or (2); and a signed informed
336.14 consent from each ~~foster care recipient~~ resident served by the program or the person's
336.15 legal representative documenting the person's or legal representative's agreement with
336.16 placement in the program. If electronic monitoring technology is used in the home, the
336.17 informed consent form must also explain the following:

336.18 (1) how any electronic monitoring is incorporated into the alternative supervision
336.19 system;

336.20 (2) the backup system for any electronic monitoring in times of electrical outages or
336.21 other equipment malfunctions;

336.22 (3) how the caregivers or direct support staff are trained on the use of the technology;

336.23 (4) the event types and license holder response times established under paragraph (e);

336.24 (5) how the license holder protects ~~the foster care recipient's~~ each resident's privacy
336.25 related to electronic monitoring and related to any electronically recorded data generated
336.26 by the monitoring system. A ~~foster care recipient~~ resident served by the program may
336.27 not be removed from a program under this subdivision for failure to consent to electronic
336.28 monitoring. The consent form must explain where and how the electronically recorded
336.29 data is stored, with whom it will be shared, and how long it is retained; and

336.30 (6) the risks and benefits of the alternative overnight supervision system.

336.31 The written explanations under clauses (1) to (6) may be accomplished through
336.32 cross-references to other policies and procedures as long as they are explained to the
336.33 person giving consent, and the person giving consent is offered a copy.

336.34 (g) Nothing in this section requires the applicant or license holder to develop or
336.35 maintain separate or duplicative policies, procedures, documentation, consent forms, or

337.1 individual plans that may be required for other licensing standards, if the requirements of
337.2 this section are incorporated into those documents.

337.3 (h) The commissioner may grant variances to the requirements of this section
337.4 according to section 245A.04, subdivision 9.

337.5 (i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning
337.6 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
337.7 contractors affiliated with the license holder.

337.8 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to
337.9 remotely determine what action the license holder needs to take to protect the well-being
337.10 of the foster care recipient.

337.11 (k) The commissioner shall evaluate license applications using the requirements
337.12 in paragraphs (d) to (f). The commissioner shall provide detailed application forms,
337.13 including a checklist of criteria needed for approval.

337.14 (l) To be eligible for a license under paragraph (a), the adult foster care or community
337.15 residential setting license holder must not have had a conditional license issued under
337.16 section 245A.06 or any licensing sanction under section 245A.07 during the prior 24
337.17 months based on failure to provide adequate supervision, health care services, or resident
337.18 safety in the adult foster care home or community residential setting.

337.19 (m) The commissioner shall review an application for an alternative overnight
337.20 supervision license within 60 days of receipt of the application. When the commissioner
337.21 receives an application that is incomplete because the applicant failed to submit required
337.22 documents or that is substantially deficient because the documents submitted do not meet
337.23 licensing requirements, the commissioner shall provide the applicant written notice
337.24 that the application is incomplete or substantially deficient. In the written notice to the
337.25 applicant, the commissioner shall identify documents that are missing or deficient and
337.26 give the applicant 45 days to resubmit a second application that is substantially complete.
337.27 An applicant's failure to submit a substantially complete application after receiving
337.28 notice from the commissioner is a basis for license denial under section 245A.05. The
337.29 commissioner shall complete subsequent review within 30 days.

337.30 (n) Once the application is considered complete under paragraph (m), the
337.31 commissioner will approve or deny an application for an alternative overnight supervision
337.32 license within 60 days.

337.33 (o) For the purposes of this subdivision, "supervision" means:

337.34 (1) oversight by a caregiver or direct support staff as specified in the individual
337.35 resident's place agreement or coordinated service and support plan and awareness of the
337.36 resident's needs and activities; and

338.1 (2) the presence of a caregiver or direct support staff in a residence during normal
338.2 sleeping hours, unless a determination has been made and documented in the individual's
338.3 coordinated service and support plan that the individual does not require the presence of a
338.4 caregiver or direct support staff during normal sleeping hours.

338.5 Sec. 19. Minnesota Statutes 2012, section 245A.11, subdivision 7b, is amended to read:

338.6 Subd. 7b. **Adult foster care data privacy and security.** (a) An adult foster care
338.7 or community residential setting license holder who creates, collects, records, maintains,
338.8 stores, or discloses any individually identifiable recipient data, whether in an electronic
338.9 or any other format, must comply with the privacy and security provisions of applicable
338.10 privacy laws and regulations, including:

338.11 (1) the federal Health Insurance Portability and Accountability Act of 1996
338.12 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations,
338.13 title 45, part 160, and subparts A and E of part 164; and

338.14 (2) the Minnesota Government Data Practices Act as codified in chapter 13.

338.15 (b) For purposes of licensure, the license holder shall be monitored for compliance
338.16 with the following data privacy and security provisions:

338.17 (1) the license holder must control access to data on ~~foster care recipients~~ residents
338.18 served by the program according to the definitions of public and private data on individuals
338.19 under section 13.02; classification of the data on individuals as private under section
338.20 13.46, subdivision 2; and control over the collection, storage, use, access, protection,
338.21 and contracting related to data according to section 13.05, in which the license holder is
338.22 assigned the duties of a government entity;

338.23 (2) the license holder must provide each ~~foster care recipient~~ resident served by
338.24 the program with a notice that meets the requirements under section 13.04, in which
338.25 the license holder is assigned the duties of the government entity, and that meets the
338.26 requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall
338.27 describe the purpose for collection of the data, and to whom and why it may be disclosed
338.28 pursuant to law. The notice must inform the ~~recipient~~ individual that the license holder
338.29 uses electronic monitoring and, if applicable, that recording technology is used;

338.30 (3) the license holder must not install monitoring cameras in bathrooms;

338.31 (4) electronic monitoring cameras must not be concealed from the ~~foster care~~
338.32 recipients residents served by the program; and

338.33 (5) electronic video and audio recordings of ~~foster care recipients~~ residents served
338.34 by the program shall be stored by the license holder for five days unless: (i) a ~~foster care~~
338.35 recipient resident served by the program or legal representative requests that the recording

339.1 be held longer based on a specific report of alleged maltreatment; or (ii) the recording
339.2 captures an incident or event of alleged maltreatment under section 626.556 or 626.557 or
339.3 a crime under chapter 609. When requested by a ~~recipient~~ resident served by the program
339.4 or when a recording captures an incident or event of alleged maltreatment or a crime, the
339.5 license holder must maintain the recording in a secured area for no longer than 30 days
339.6 to give the investigating agency an opportunity to make a copy of the recording. The
339.7 investigating agency will maintain the electronic video or audio recordings as required in
339.8 section 626.557, subdivision 12b.

339.9 (c) The commissioner shall develop, and make available to license holders and
339.10 county licensing workers, a checklist of the data privacy provisions to be monitored
339.11 for purposes of licensure.

339.12 Sec. 20. Minnesota Statutes 2012, section 245A.11, subdivision 8, is amended to read:

339.13 Subd. 8. **Community residential setting license.** (a) The commissioner shall
339.14 establish provider standards for residential support services that integrate service standards
339.15 and the residential setting under one license. The commissioner shall propose statutory
339.16 language and an implementation plan for licensing requirements for residential support
339.17 services to the legislature by January 15, 2012, as a component of the quality outcome
339.18 standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

339.19 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
339.20 for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105
339.21 to 9555.6265, ~~or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340;~~
339.22 and meeting the provisions of ~~section 256B.092, subdivision 11, paragraph (b)~~ section
339.23 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

339.24 Sec. 21. Minnesota Statutes 2012, section 245A.16, subdivision 1, is amended to read:

339.25 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
339.26 private agencies that have been designated or licensed by the commissioner to perform
339.27 licensing functions and activities under section 245A.04 and background studies for family
339.28 child care under chapter 245C; to recommend denial of applicants under section 245A.05;
339.29 to issue correction orders, to issue variances, and recommend a conditional license under
339.30 section 245A.06, or to recommend suspending or revoking a license or issuing a fine under
339.31 section 245A.07, shall comply with rules and directives of the commissioner governing
339.32 those functions and with this section. The following variances are excluded from the
339.33 delegation of variance authority and may be issued only by the commissioner:

- 340.1 (1) dual licensure of family child care and child foster care, dual licensure of child
340.2 and adult foster care, and adult foster care and family child care;
- 340.3 (2) adult foster care maximum capacity;
- 340.4 (3) adult foster care minimum age requirement;
- 340.5 (4) child foster care maximum age requirement;
- 340.6 (5) variances regarding disqualified individuals except that county agencies may
340.7 issue variances under section 245C.30 regarding disqualified individuals when the county
340.8 is responsible for conducting a consolidated reconsideration according to sections 245C.25
340.9 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
340.10 and a disqualification based on serious or recurring maltreatment; ~~and~~
- 340.11 (6) the required presence of a caregiver in the adult foster care residence during
340.12 normal sleeping hours; and
- 340.13 (7) variances for community residential setting licenses under chapter 245D.
- 340.14 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency
340.15 must not grant a license holder a variance to exceed the maximum allowable family child
340.16 care license capacity of 14 children.
- 340.17 (b) County agencies must report information about disqualification reconsiderations
340.18 under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances
340.19 granted under paragraph (a), clause (5), to the commissioner at least monthly in a format
340.20 prescribed by the commissioner.
- 340.21 (c) For family day care programs, the commissioner may authorize licensing reviews
340.22 every two years after a licensee has had at least one annual review.
- 340.23 (d) For family adult day services programs, the commissioner may authorize
340.24 licensing reviews every two years after a licensee has had at least one annual review.
- 340.25 (e) A license issued under this section may be issued for up to two years.
- 340.26 (f) During implementation of chapter 245D, the commissioner shall consider:
- 340.27 (1) the role of counties in quality assurance;
- 340.28 (2) the duties of county licensing staff; and
- 340.29 (3) the possible use of joint powers agreements, according to section 471.59, with
340.30 counties through which some licensing duties under chapter 245D may be delegated by
340.31 the commissioner to the counties.
- 340.32 Any consideration related to this paragraph must meet all of the requirements of the
340.33 corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

340.34 Sec. 22. Minnesota Statutes 2012, section 245D.02, is amended to read:

340.35 **245D.02 DEFINITIONS.**

341.1 Subdivision 1. **Scope.** The terms used in this chapter have the meanings given
341.2 them in this section.

341.3 Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given
341.4 in section 245A.02, subdivision 2b.

341.5 Subd. 2a. **Authorized representative.** "Authorized representative" means a parent,
341.6 family member, advocate, or other adult authorized by the person or the person's legal
341.7 representative, to serve as a representative in connection with the provision of services
341.8 licensed under this chapter. This authorization must be in writing or by another method
341.9 that clearly indicates the person's free choice. The authorized representative must have no
341.10 financial interest in the provision of any services included in the person's service delivery
341.11 plan and must be capable of providing the support necessary to assist the person in the use
341.12 of home and community-based services licensed under this chapter.

341.13 Subd. 2b. **Aversive procedure.** "Aversive procedure" means the application of
341.14 an aversive stimulus contingent upon the occurrence of a behavior for the purposes of
341.15 reducing or eliminating the behavior.

341.16 Subd. 2c. **Aversive stimulus.** "Aversive stimulus" means an object, event, or
341.17 situation that is presented immediately following a behavior in an attempt to suppress the
341.18 behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines.

341.19 Subd. 3. **Case manager.** "Case manager" means the individual designated
341.20 to provide waiver case management services, care coordination, or long-term care
341.21 consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,
341.22 or successor provisions.

341.23 Subd. 3a. **Certification.** "Certification" means the commissioner's written
341.24 authorization for a license holder to provide specialized services based on certification
341.25 standards in section 245D.33. The term certification and its derivatives have the same
341.26 meaning and may be substituted for the term licensure and its derivatives in this chapter
341.27 and chapter 245A.

341.28 Subd. 3b. **Chemical restraint.** "Chemical restraint" means the administration of
341.29 a drug or medication to control the person's behavior or restrict the person's freedom
341.30 of movement and is not a standard treatment or dosage for the person's medical or
341.31 psychological condition.

341.32 Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the
341.33 Department of Human Services or the commissioner's designated representative.

341.34 Subd. 4a. **Community residential setting.** "Community residential setting" means
341.35 a residential program as identified in section 245A.11, subdivision 8, where residential
341.36 supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause

342.1 (3), items (i) and (ii), are provided and the license holder is the owner, lessor, or tenant
342.2 of the facility licensed according to this chapter, and the license holder does not reside
342.3 in the facility.

342.4 Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support
342.5 plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision
342.6 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions.

342.7 Subd. 4c. **Coordinated service and support plan addendum.** "Coordinated
342.8 service and support plan addendum" means the documentation that this chapter requires
342.9 of the license holder for each person receiving services.

342.10 Subd. 4d. **Corporate foster care.** "Corporate foster care" means a child foster
342.11 residence setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340,
342.12 or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to
342.13 9555.6265, where the license holder does not live in the home.

342.14 Subd. 4e. **Cultural competence or culturally competent.** "Cultural competence"
342.15 or "culturally competent" means the ability and the will to respond to the unique needs of
342.16 a person that arise from the person's culture and the ability to use the person's culture as a
342.17 resource or tool to assist with the intervention and help meet the person's needs.

342.18 Subd. 4f. **Day services facility.** "Day services facility" means a facility licensed
342.19 according to this chapter at which persons receive day services licensed under this chapter
342.20 from the license holder's direct support staff for a cumulative total of more than 30 days
342.21 within any 12-month period and the license holder is the owner, lessor, or tenant of the
342.22 facility.

342.23 Subd. 5. **Department.** "Department" means the Department of Human Services.

342.24 Subd. 5a. **Deprivation procedure.** "Deprivation procedure" means the removal of a
342.25 positive reinforcer following a response resulting in, or intended to result in, a decrease in
342.26 the frequency, duration, or intensity of that response. Oftentimes the positive reinforcer
342.27 available is goods, services, or activities to which the person is normally entitled. The
342.28 removal is often in the form of a delay or postponement of the positive reinforcer.

342.29 Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02,
342.30 subdivision 11, and is used interchangeably with the term "direct support service."

342.31 Subd. 6a. **Direct support staff or staff.** "Direct support staff" or "staff" means
342.32 employees of the license holder who have direct contact with persons served by the
342.33 program and includes temporary staff or subcontractors, regardless of employer, providing
342.34 program services for hire under the control of the license holder who have direct contact
342.35 with persons served by the program.

342.36 Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

343.1 Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary
343.2 daily operation of the program including, but not limited to, fires, severe weather, natural
343.3 disasters, power failures, or other events that threaten the immediate health and safety of
343.4 a person receiving services and that require calling 911, emergency evacuation, moving
343.5 to an emergency shelter, or temporary closure or relocation of the program to another
343.6 facility or service site for more than 24 hours.

343.7 Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual
343.8 restraint" means using a manual restraint when a person poses an imminent risk of
343.9 physical harm to self or others and is the least restrictive intervention that would achieve
343.10 safety. Property damage, verbal aggression, or a person's refusal to receive or participate
343.11 in treatment or programming on their own, do not constitute an emergency.

343.12 Subd. 8b. **Expanded support team.** "Expanded support team" means the members
343.13 of the support team defined in subdivision 46, and a licensed health or mental health
343.14 professional or other licensed, certified, or qualified professionals or consultants working
343.15 with the person and included in the team at the request of the person or the person's legal
343.16 representative.

343.17 Subd. 8c. **Family foster care.** "Family foster care" means a child foster family
343.18 setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult
343.19 foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265,
343.20 where the license holder lives in the home.

343.21 Subd. 9. **Health services.** "Health services" means any service or treatment
343.22 consistent with the physical and mental health needs of the person, such as medication
343.23 administration and monitoring, medical, dental, nutritional, health monitoring, wellness
343.24 education, and exercise.

343.25 Subd. 10. **Home and community-based services.** "Home and community-based
343.26 services" means the services ~~subject to the provisions of this chapter~~ identified in section
343.27 245D.03, subdivision 1, and as defined in:

343.28 (1) the federal ~~federally~~ approved waiver plans governed by United States Code,
343.29 title 42, sections 1396 et seq., or the state's alternative care program according to section
343.30 256B.0913; including the waivers for persons with disabilities under section 256B.49,
343.31 subdivision 11, including the brain injury (BI) waiver; plan; the community alternative
343.32 care (CAC) waiver; plan; the community alternatives for disabled individuals (CADI)
343.33 waiver; plan; the developmental disability (DD) waiver; plan under section 256B.092,
343.34 subdivision 5; the elderly waiver (EW), and plan under section 256B.0915, subdivision 1;
343.35 or successor plans respective to each waiver; or

343.36 (2) the alternative care (AC) program under section 256B.0913.

344.1 Subd. 11. **Incident.** "Incident" means an occurrence ~~that affects the~~ which involves
344.2 a person and requires the program to make a response that is not a part of the program's
344.3 ordinary provision of services to a that person, and includes ~~any of the following:~~

344.4 (1) serious injury of a person as determined by section 245.91, subdivision 6;

344.5 (2) a person's death;

344.6 (3) any medical emergency, unexpected serious illness, or significant unexpected
344.7 change in an illness or medical condition, ~~or the mental health status of a person that~~
344.8 requires calling the program to call 911 or a mental health crisis intervention team,
344.9 physician treatment, or hospitalization;

344.10 (4) any mental health crisis that requires the program to call 911 or a mental health
344.11 crisis intervention team;

344.12 (5) an act or situation involving a person that requires the program to call 911,
344.13 law enforcement, or the fire department;

344.14 ~~(4)~~ (6) a person's unauthorized or unexplained absence from a program;

344.15 ~~(5)~~ (7) physical aggression conduct by a person receiving services against another
344.16 person receiving services that causes physical pain, injury, or persistent emotional distress,
344.17 including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting,
344.18 pushing, and spitting;

344.19 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with
344.20 a person's opportunities to participate in or receive service or support;

344.21 (ii) places the person in actual and reasonable fear of harm;

344.22 (iii) places the person in actual and reasonable fear of damage to property of the
344.23 person; or

344.24 (iv) substantially disrupts the orderly operation of the program;

344.25 ~~(6)~~ (8) any sexual activity between persons receiving services involving force or
344.26 coercion as defined under section 609.341, subdivisions 3 and 14; or

344.27 (9) any emergency use of manual restraint as identified in section 245D.061; or

344.28 ~~(7)~~ (10) a report of alleged or suspected child or vulnerable adult maltreatment
344.29 under section 626.556 or 626.557.

344.30 Subd. 11a. **Intermediate care facility for persons with developmental disabilities**
344.31 **or ICF/DD.** "Intermediate care facility for persons with developmental disabilities" or
344.32 "ICF/DD" means a residential program licensed to serve four or more persons with
344.33 developmental disabilities under section 252.28 and chapter 245A and licensed as a
344.34 supervised living facility under chapter 144, which together are certified by the Department
344.35 of Health as an intermediate care facility for persons with developmental disabilities.

345.1 Subd. 11b. **Least restrictive alternative.** "Least restrictive alternative" means
345.2 the alternative method for providing supports and services that is the least intrusive and
345.3 most normalized given the level of supervision and protection required for the person.
345.4 This level of supervision and protection allows risk taking to the extent that there is no
345.5 reasonable likelihood that serious harm will happen to the person or others.

345.6 **Subd. 12. Legal representative.** "Legal representative" means the parent of a
345.7 person who is under 18 years of age, a court-appointed guardian, or other representative
345.8 with legal authority to make decisions about services for a person. Other representatives
345.9 with legal authority to make decisions include but are not limited to a health care agent or
345.10 an attorney-in-fact authorized through a health care directive or power of attorney.

345.11 **Subd. 13. License.** "License" has the meaning given in section 245A.02,
345.12 subdivision 8.

345.13 **Subd. 14. Licensed health professional.** "Licensed health professional" means a
345.14 person licensed in Minnesota to practice those professions described in section 214.01,
345.15 subdivision 2.

345.16 **Subd. 15. License holder.** "License holder" has the meaning given in section
345.17 245A.02, subdivision 9.

345.18 Subd. 15a. **Manual restraint.** "Manual restraint" means physical intervention
345.19 intended to hold a person immobile or limit a person's voluntary movement by using body
345.20 contact as the only source of physical restraint.

345.21 Subd. 15b. **Mechanical restraint.** Except for devices worn by the person that
345.22 trigger electronic alarms to warn staff that a person is leaving a room or area, which
345.23 do not, in and of themselves, restrict freedom of movement, or the use of adaptive aids
345.24 or equipment or orthotic devices ordered by a health care professional used to treat or
345.25 manage a medical condition, "mechanical restraint" means the use of devices, materials,
345.26 or equipment attached or adjacent to the person's body, or the use of practices that are
345.27 intended to restrict freedom of movement or normal access to one's body or body parts,
345.28 or limits a person's voluntary movement or holds a person immobile as an intervention
345.29 precipitated by a person's behavior. The term applies to the use of mechanical restraint
345.30 used to prevent injury with persons who engage in self-injurious behaviors, such as
345.31 head-banging, gouging, or other actions resulting in tissue damage that have caused or
345.32 could cause medical problems resulting from the self-injury.

345.33 **Subd. 16. Medication.** "Medication" means a prescription drug or over-the-counter
345.34 drug. For purposes of this chapter, "medication" includes dietary supplements.

345.35 ~~**Subd. 17. Medication administration.** "Medication administration" means~~
345.36 ~~performing the following set of tasks to ensure a person takes both prescription and~~

346.1 ~~over-the-counter medications and treatments according to orders issued by appropriately~~
346.2 ~~licensed professionals, and includes the following:~~

- 346.3 ~~(1) checking the person's medication record;~~
- 346.4 ~~(2) preparing the medication for administration;~~
- 346.5 ~~(3) administering the medication to the person;~~
- 346.6 ~~(4) documenting the administration of the medication or the reason for not~~
346.7 ~~administering the medication; and~~
- 346.8 ~~(5) reporting to the prescriber or a nurse any concerns about the medication,~~
346.9 ~~including side effects, adverse reactions, effectiveness, or the person's refusal to take the~~
346.10 ~~medication or the person's self-administration of the medication.~~

346.11 ~~Subd. 18. **Medication assistance.** "Medication assistance" means providing verbal~~
346.12 ~~or visual reminders to take regularly scheduled medication, which includes either of~~
346.13 ~~the following:~~

- 346.14 ~~(1) bringing to the person and opening a container of previously set up medications~~
346.15 ~~and emptying the container into the person's hand or opening and giving the medications~~
346.16 ~~in the original container to the person, or bringing to the person liquids or food to~~
346.17 ~~accompany the medication; or~~
- 346.18 ~~(2) providing verbal or visual reminders to perform regularly scheduled treatments~~
346.19 ~~and exercises.~~

346.20 ~~Subd. 19. **Medication management.** "Medication management" means the~~
346.21 ~~provision of any of the following:~~

- 346.22 ~~(1) medication-related services to a person;~~
- 346.23 ~~(2) medication setup;~~
- 346.24 ~~(3) medication administration;~~
- 346.25 ~~(4) medication storage and security;~~
- 346.26 ~~(5) medication documentation and charting;~~
- 346.27 ~~(6) verification and monitoring of effectiveness of systems to ensure safe medication~~
346.28 ~~handling and administration;~~
- 346.29 ~~(7) coordination of medication refills;~~
- 346.30 ~~(8) handling changes to prescriptions and implementation of those changes;~~
- 346.31 ~~(9) communicating with the pharmacy; or~~
- 346.32 ~~(10) coordination and communication with prescriber.~~

346.33 ~~For the purposes of this chapter, medication management does not mean "medication~~
346.34 ~~therapy management services" as identified in section 256B.0625, subdivision 13h.~~

346.35 ~~Subd. 20. **Mental health crisis intervention team.** "Mental health crisis~~
346.36 ~~intervention team" means a mental health crisis response providers provider as identified~~

347.1 in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944,
347.2 subdivision 1, paragraph (d), for children.

347.3 Subd. 20a. **Most integrated setting.** "Most integrated setting" means a setting that
347.4 enables individuals with disabilities to interact with nondisabled persons to the fullest
347.5 extent possible.

347.6 Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that
347.7 is not required by federal law to bear the statement "Caution: Federal law prohibits
347.8 dispensing without prescription."

347.9 Subd. 21a. **Outcome.** "Outcome" means the behavior, action, or status attained by
347.10 the person that can be observed, measured, and determined reliable and valid.

347.11 Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision
347.12 11.

347.13 Subd. 23. **Person with a disability.** "Person with a disability" means a person
347.14 determined to have a disability by the commissioner's state medical review team as
347.15 identified in section 256B.055, subdivision 7, the Social Security Administration, or
347.16 the person is determined to have a developmental disability as defined in Minnesota
347.17 Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section
347.18 252.27, subdivision 1a.

347.19 Subd. 23a. **Physician.** "Physician" means a person who is licensed under chapter
347.20 147.

347.21 Subd. 23b. **Positive support transition plan.** "Positive support transition plan"
347.22 means the plan required in section 245D.06, subdivision 5, paragraph (b), to be developed
347.23 by the expanded support team to implement positive support strategies to:

347.24 (1) eliminate the use of prohibited procedures as identified in section 245D.06,
347.25 subdivision 5, paragraph (a);

347.26 (2) avoid the emergency use of manual restraint as identified in section 245D.061; and

347.27 (3) prevent the person from physically harming self or others.

347.28 Subd. 24. **Prescriber.** "Prescriber" means a ~~licensed practitioner as defined in~~
347.29 ~~section 151.01, subdivision 23, person~~ who is authorized under section 148.235; 151.01,
347.30 subdivision 23; or 151.37 to prescribe drugs. For the purposes of this chapter, the term
347.31 "prescriber" is used interchangeably with "physician."

347.32 Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section
347.33 151.01, subdivision ~~17~~ 16.

347.34 Subd. 26. **Program.** "Program" means either the nonresidential or residential
347.35 program as defined in section 245A.02, subdivisions 10 and 14.

348.1 Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any
348.2 medication prescribed to treat the symptoms of mental illness that affect thought processes,
348.3 mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic
348.4 (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and
348.5 stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder.
348.6 Other miscellaneous medications are considered to be a psychotropic medication when
348.7 they are specifically prescribed to treat a mental illness or to control or alter behavior.

348.8 Subd. 28. **Restraint.** "Restraint" means ~~physical or mechanical~~ manual restraint
348.9 as defined in subdivision 15a or mechanical restraint as defined in subdivision 15b, or
348.10 any other form of restraint that results in limiting of the free and normal movement of
348.11 body or limbs.

348.12 Subd. 29. **Seclusion.** "Seclusion" means ~~separating a person from others in a way~~
348.13 ~~that prevents social contact and prevents the person from leaving the situation if he or she~~
348.14 ~~chooses~~ the placement of a person alone in a room from which exit is prohibited by a staff
348.15 person or a mechanism such as a lock, a device, or an object positioned to hold the door
348.16 closed or otherwise prevent the person from leaving the room.

348.17 Subd. 29a. **Self-determination.** "Self-determination" means the person makes
348.18 decisions independently, plans for the person's own future, determines how money is spent
348.19 for the person's supports, and takes responsibility for making these decisions. If a person
348.20 has a legal representative, the legal representative's decision-making authority is limited to
348.21 the scope of authority granted by the court or allowed in the document authorizing the
348.22 legal representative to act.

348.23 Subd. 29b. **Semi-independent living services.** "Semi-independent living services"
348.24 has the meaning given in section 252.275.

348.25 Subd. 30. **Service.** "Service" means care, training, supervision, counseling,
348.26 consultation, or medication assistance assigned to the license holder in the coordinated
348.27 service and support plan.

348.28 Subd. 31. **Service plan.** "Service plan" ~~means the individual service plan or~~
348.29 ~~individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,~~
348.30 ~~or successor provisions, and includes any support plans or service needs identified as~~
348.31 ~~a result of long-term care consultation, or a support team meeting that includes the~~
348.32 ~~participation of the person, the person's legal representative, and case manager, or assigned~~
348.33 ~~to a license holder through an authorized service agreement.~~

348.34 Subd. 32. **Service site.** "Service site" means the location where the service is
348.35 provided to the person, including, but not limited to, a facility licensed according to

349.1 chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's
349.2 own home; or a community-based location.

349.3 ~~Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a~~
349.4 ~~person served by the facility, agency, or program.~~

349.5 Subd. 33a. **Supervised living facility.** "Supervised living facility" has the meaning
349.6 given in Minnesota Rules, part 4665.0100, subpart 10.

349.7 Subd. 33b. **Supervision.** (a) "Supervision" means:

349.8 (1) oversight by direct support staff as specified in the person's coordinated service
349.9 and support plan or coordinated service and support plan addendum and awareness of
349.10 the person's needs and activities;

349.11 (2) responding to situations that present a serious risk to the health, safety, or rights
349.12 of the person while services are being provided; and

349.13 (3) the presence of direct support staff at a service site while services are being
349.14 provided, unless a determination has been made and documented in the person's coordinated
349.15 service and support plan or coordinated service and support plan addendum that the person
349.16 does not require the presence of direct support staff while services are being provided.

349.17 (b) For the purposes of this definition, "while services are being provided," means
349.18 any period of time during which the license holder will seek reimbursement for services.

349.19 **Subd. 34. **Support team.** "Support team" means the service planning team**
349.20 **identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in**
349.21 **Minnesota Rules, part 9525.0004, subpart 14.**

349.22 Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an
349.23 ongoing activity to a room, either locked or unlocked, or otherwise separating a person
349.24 from others in a way that prevents social contact and prevents the person from leaving
349.25 the situation if the person chooses. For the purpose of chapter 245D, "time out" does
349.26 not mean voluntary removal or self-removal for the purpose of calming, prevention of
349.27 escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out"
349.28 does not include a person voluntarily moving from an ongoing activity to an unlocked
349.29 room or otherwise separating from a situation or social contact with others if the person
349.30 chooses. For the purposes of this definition, "voluntarily" means without being forced,
349.31 compelled, or coerced.

349.32 ~~Subd. 35. **Unit of government.** "Unit of government" means every city, county,~~
349.33 ~~town, school district, other political subdivisions of the state, and any agency of the state~~
349.34 ~~or the United States, and includes any instrumentality of a unit of government.~~

350.1 Subd. 35a. **Treatment.** "Treatment" means the provision of care, other than
350.2 medications, ordered or prescribed by a licensed health or mental health professional,
350.3 provided to a person to cure, rehabilitate, or ease symptoms.

350.4 Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the
350.5 license holder, provides direct services without pay to a person served by the license holder.

350.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

350.7 Sec. 23. Minnesota Statutes 2012, section 245D.03, is amended to read:

350.8 **245D.03 APPLICABILITY AND EFFECT.**

350.9 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of
350.10 home and community-based services to persons with disabilities and persons age 65 and
350.11 older pursuant to this chapter. The licensing standards in this chapter govern the provision
350.12 of the following basic support services; and intensive support services.

350.13 ~~(1) housing access coordination as defined under the current BI, CADI, and DD~~
350.14 ~~waiver plans or successor plans;~~

350.15 ~~(2) respite services as defined under the current CADI, BI, CAC, DD, and EW~~
350.16 ~~waiver plans or successor plans when the provider is an individual who is not an employee~~
350.17 ~~of a residential or nonresidential program licensed by the Department of Human Services~~
350.18 ~~or the Department of Health that is otherwise providing the respite service;~~

350.19 ~~(3) behavioral programming as defined under the current BI and CADI waiver~~
350.20 ~~plans or successor plans;~~

350.21 ~~(4) specialist services as defined under the current DD waiver plan or successor plans;~~

350.22 ~~(5) companion services as defined under the current BI, CADI, and EW waiver~~
350.23 ~~plans or successor plans, excluding companion services provided under the Corporation~~
350.24 ~~for National and Community Services Senior Companion Program established under the~~
350.25 ~~Domestic Volunteer Service Act of 1973, Public Law 98-288;~~

350.26 ~~(6) personal support as defined under the current DD waiver plan or successor plans;~~

350.27 ~~(7) 24-hour emergency assistance, on-call and personal emergency response as~~
350.28 ~~defined under the current CADI and DD waiver plans or successor plans;~~

350.29 ~~(8) night supervision services as defined under the current BI waiver plan or~~
350.30 ~~successor plans;~~

350.31 ~~(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW~~
350.32 ~~waiver plans or successor plans, excluding providers licensed by the Department of Health~~
350.33 ~~under chapter 144A and those providers providing cleaning services only;~~

351.1 ~~(10) independent living skills training as defined under the current BI and CADI~~
351.2 ~~waiver plans or successor plans;~~

351.3 ~~(11) prevocational services as defined under the current BI and CADI waiver plans~~
351.4 ~~or successor plans;~~

351.5 ~~(12) structured day services as defined under the current BI waiver plan or successor~~
351.6 ~~plans; or~~

351.7 ~~(13) supported employment as defined under the current BI and CADI waiver plans~~
351.8 ~~or successor plans.~~

351.9 (b) Basic support services provide the level of assistance, supervision, and care that
351.10 is necessary to ensure the health and safety of the person and do not include services that
351.11 are specifically directed toward the training, treatment, habilitation, or rehabilitation of
351.12 the person. Basic support services include:

351.13 (1) in-home and out-of-home respite care services as defined in section 245A.02,
351.14 subdivision 15, and under the brain injury, community alternative care, community
351.15 alternatives for disabled individuals, developmental disability, and elderly waiver plans;

351.16 (2) companion services as defined under the brain injury, community alternatives for
351.17 disabled individuals, and elderly waiver plans, excluding companion services provided
351.18 under the Corporation for National and Community Services Senior Companion Program
351.19 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

351.20 (3) personal support as defined under the developmental disability waiver plan;

351.21 (4) 24-hour emergency assistance, personal emergency response as defined under the
351.22 community alternatives for disabled individuals and developmental disability waiver plans;

351.23 (5) night supervision services as defined under the brain injury waiver plan; and

351.24 (6) homemaker services as defined under the community alternatives for disabled
351.25 individuals, brain injury, community alternative care, developmental disability, and elderly
351.26 waiver plans, excluding providers licensed by the Department of Health under chapter
351.27 144A and those providers providing cleaning services only.

351.28 (c) Intensive support services provide assistance, supervision, and care that is
351.29 necessary to ensure the health and safety of the person and services specifically directed
351.30 toward the training, habilitation, or rehabilitation of the person. Intensive support services
351.31 include:

351.32 (1) intervention services, including:

351.33 (i) behavioral support services as defined under the brain injury and community
351.34 alternatives for disabled individuals waiver plans;

351.35 (ii) in-home or out-of-home crisis respite services as defined under the developmental
351.36 disability waiver plan; and

- 352.1 (iii) specialist services as defined under the current developmental disability waiver
352.2 plan;
- 352.3 (2) in-home support services, including:
- 352.4 (i) in-home family support and supported living services as defined under the
352.5 developmental disability waiver plan;
- 352.6 (ii) independent living services training as defined under the brain injury and
352.7 community alternatives for disabled individuals waiver plans; and
- 352.8 (iii) semi-independent living services;
- 352.9 (3) residential supports and services, including:
- 352.10 (i) supported living services as defined under the developmental disability waiver
352.11 plan provided in a family or corporate child foster care residence, a family adult foster
352.12 care residence, a community residential setting, or a supervised living facility;
- 352.13 (ii) foster care services as defined in the brain injury, community alternative care,
352.14 and community alternatives for disabled individuals waiver plans provided in a family or
352.15 corporate child foster care residence, a family adult foster care residence, or a community
352.16 residential setting; and
- 352.17 (iii) residential services provided in a supervised living facility that is certified by
352.18 the Department of Health as an ICF/DD;
- 352.19 (4) day services, including:
- 352.20 (i) structured day services as defined under the brain injury waiver plan;
- 352.21 (ii) day training and habilitation services under sections 252.40 to 252.46, and as
352.22 defined under the developmental disability waiver plan; and
- 352.23 (iii) prevocational services as defined under the brain injury and community
352.24 alternatives for disabled individuals waiver plans; and
- 352.25 (5) supported employment as defined under the brain injury, developmental
352.26 disability, and community alternatives for disabled individuals waiver plans.

352.27 **Subd. 2. Relationship to other standards governing home and community-based**
352.28 **services.** (a) A license holder governed by this chapter is also subject to the licensure
352.29 requirements under chapter 245A.

352.30 (b) ~~A license holder concurrently providing child foster care services licensed~~
352.31 ~~according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed~~
352.32 ~~under this chapter is exempt from section 245D.04 as it applies to the person. A corporate~~
352.33 ~~or family child foster care site controlled by a license holder and providing services~~
352.34 ~~governed by this chapter is exempt from compliance with section 245D.04. This exemption~~
352.35 ~~applies to foster care homes where at least one resident is receiving residential supports~~

353.1 and services licensed according to this chapter. This chapter does not apply to corporate or
353.2 family child foster care homes that do not provide services licensed under this chapter.

353.3 (c) A family adult foster care site controlled by a license holder and providing
353.4 services governed by this chapter is exempt from compliance with Minnesota Rules,
353.5 parts 9555.6185; 9555.6225; 9555.6245; 9555.6255; and 9555.6265. These exemptions
353.6 apply to family adult foster care homes where at least one resident is receiving residential
353.7 supports and services licensed according to this chapter. This chapter does not apply to
353.8 family adult foster care homes that do not provide services licensed under this chapter.

353.9 (d) A license holder providing services licensed according to this chapter in a
353.10 supervised living facility is exempt from compliance with sections 245D.04; 245D.05,
353.11 subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5).

353.12 (e) A license holder providing residential services to persons in an ICF/DD is exempt
353.13 from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision
353.14 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09,
353.15 subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

353.16 ~~(e) (f) A license holder concurrently providing home care homemaker services~~
353.17 ~~registered licensed according to sections 144A.43 to 144A.49 to the same person receiving~~
353.18 ~~home management services licensed under this chapter and registered according to chapter~~
353.19 ~~144A is exempt from compliance with section 245D.04 as it applies to the person.~~

353.20 ~~(d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt~~
353.21 ~~from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557,~~
353.22 ~~subdivision 14, paragraph (b).~~

353.23 ~~(e) Notwithstanding section 245D.06, subdivision 5, a license holder providing~~
353.24 ~~structured day, prevocational, or supported employment services under this chapter~~
353.25 ~~and day training and habilitation or supported employment services licensed under~~
353.26 ~~chapter 245B within the same program is exempt from compliance with this chapter~~
353.27 ~~when the license holder notifies the commissioner in writing that the requirements under~~
353.28 ~~chapter 245B will be met for all persons receiving these services from the program. For~~
353.29 ~~the purposes of this paragraph, if the license holder has obtained approval from the~~
353.30 ~~commissioner for an alternative inspection status according to section 245B.031, that~~
353.31 ~~approval will apply to all persons receiving services in the program.~~

353.32 (g) Nothing in this chapter prohibits a license holder from concurrently serving
353.33 persons without disabilities or people who are or are not age 65 and older, provided this
353.34 chapter's standards are met as well as other relevant standards.

354.1 (h) The documentation required under sections 245D.07 and 245D.071 must meet
354.2 the individual program plan requirements identified in section 256B.092 or successor
354.3 provisions.

354.4 Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met,
354.5 the commissioner may grant a variance to any of the requirements in this chapter, except
354.6 sections 245D.04, and ~~245D.10, subdivision 4, paragraph (b)~~ 245D.06, subdivision 4,
354.7 paragraph (b), and 245D.061, subdivision 3, or provisions governing data practices and
354.8 information rights of persons.

354.9 Subd. 4. ~~**License holders with multiple 245D licenses.** (a) When a person changes~~
354.10 ~~service from one license to a different license held by the same license holder, the license~~
354.11 ~~holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).~~

354.12 ~~(b) When a staff person begins providing direct service under one or more licenses~~
354.13 ~~held by the same license holder, other than the license for which staff orientation was~~
354.14 ~~initially provided according to section 245D.09, subdivision 4, the license holder is~~
354.15 ~~exempt from those staff orientation requirements, except the staff person must review each~~
354.16 ~~person's service plan and medication administration procedures in accordance with section~~
354.17 ~~245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.~~

354.18 Subd. 5. **Program certification.** An applicant or a license holder may apply for
354.19 program certification as identified in section 245D.33.

354.20 **EFFECTIVE DATE.** This section is effective January 1, 2014.

354.21 Sec. 24. Minnesota Statutes 2012, section 245D.04, is amended to read:

354.22 **245D.04 SERVICE RECIPIENT RIGHTS.**

354.23 Subdivision 1. **License holder responsibility for individual rights of persons**
354.24 **served by the program.** The license holder must:

354.25 (1) provide each person or each person's legal representative with a written notice
354.26 that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of
354.27 those rights within five working days of service initiation and annually thereafter;

354.28 (2) make reasonable accommodations to provide this information in other formats
354.29 or languages as needed to facilitate understanding of the rights by the person and the
354.30 person's legal representative, if any;

354.31 (3) maintain documentation of the person's or the person's legal representative's
354.32 receipt of a copy and an explanation of the rights; and

354.33 (4) ensure the exercise and protection of the person's rights in the services provided
354.34 by the license holder and as authorized in the coordinated service and support plan.

- 355.1 Subd. 2. **Service-related rights.** A person's service-related rights include the right to:
- 355.2 (1) participate in the development and evaluation of the services provided to the
- 355.3 person;
- 355.4 (2) have services and supports identified in the coordinated service and support plan
- 355.5 and the coordinated service and support plan addendum provided in a manner that respects
- 355.6 and takes into consideration the person's preferences according to the requirements in
- 355.7 sections 245D.07 and 245D.071;
- 355.8 (3) refuse or terminate services and be informed of the consequences of refusing
- 355.9 or terminating services;
- 355.10 (4) know, in advance, limits to the services available from the license holder₂,
- 355.11 including the license holder's knowledge, skill, and ability to meet the person's service
- 355.12 and support needs;
- 355.13 (5) know conditions and terms governing the provision of services, including the
- 355.14 license holder's admission criteria and policies and procedures related to temporary
- 355.15 service suspension and service termination;
- 355.16 (6) a coordinated transfer to ensure continuity of care when there will be a change
- 355.17 in the provider;
- 355.18 (7) know what the charges are for services, regardless of who will be paying for the
- 355.19 services, and be notified of changes in those charges;
- 355.20 ~~(7)~~ (8) know, in advance, whether services are covered by insurance, government
- 355.21 funding, or other sources, and be told of any charges the person or other private party
- 355.22 may have to pay; and
- 355.23 ~~(8)~~ (9) receive services from an individual who is competent and trained, who has
- 355.24 professional certification or licensure, as required, and who meets additional qualifications
- 355.25 identified in the person's coordinated service and support plan; or coordinated service and
- 355.26 support plan addendum.
- 355.27 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include
- 355.28 the right to:
- 355.29 (1) have personal, financial, service, health, and medical information kept private,
- 355.30 and be advised of disclosure of this information by the license holder;
- 355.31 (2) access records and recorded information about the person in accordance with
- 355.32 applicable state and federal law, regulation, or rule;
- 355.33 (3) be free from maltreatment;
- 355.34 (4) be free from restraint, time out, or seclusion ~~used for a purpose other than~~ except
- 355.35 for emergency use of manual restraint to protect the person from imminent danger to self
- 355.36 or others according to the requirements in section 245D.06;

356.1 (5) receive services in a clean and safe environment when the license holder is the
356.2 owner, lessor, or tenant of the service site;

356.3 (6) be treated with courtesy and respect and receive respectful treatment of the
356.4 person's property;

356.5 (7) reasonable observance of cultural and ethnic practice and religion;

356.6 (8) be free from bias and harassment regarding race, gender, age, disability,
356.7 spirituality, and sexual orientation;

356.8 (9) be informed of and use the license holder's grievance policy and procedures,
356.9 including knowing how to contact persons responsible for addressing problems and to
356.10 appeal under section 256.045;

356.11 (10) know the name, telephone number, and the Web site, e-mail, and street
356.12 addresses of protection and advocacy services, including the appropriate state-appointed
356.13 ombudsman, and a brief description of how to file a complaint with these offices;

356.14 (11) assert these rights personally, or have them asserted by the person's family,
356.15 authorized representative, or legal representative, without retaliation;

356.16 (12) give or withhold written informed consent to participate in any research or
356.17 experimental treatment;

356.18 (13) associate with other persons of the person's choice;

356.19 (14) personal privacy; and

356.20 (15) engage in chosen activities.

356.21 (b) For a person residing in a residential site licensed according to chapter 245A,
356.22 or where the license holder is the owner, lessor, or tenant of the residential service site,
356.23 protection-related rights also include the right to:

356.24 (1) have daily, private access to and use of a non-coin-operated telephone for local
356.25 calls and long-distance calls made collect or paid for by the person;

356.26 (2) receive and send, without interference, uncensored, unopened mail or electronic
356.27 correspondence or communication; ~~and~~

356.28 (3) have use of and free access to common areas in the residence; and

356.29 (4) privacy for visits with the person's spouse, next of kin, legal counsel, religious
356.30 advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including
356.31 privacy in the person's bedroom.

356.32 (c) Restriction of a person's rights under subdivision 2, clause (10), or paragraph (a),
356.33 clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure
356.34 the health, safety, and well-being of the person. Any restriction of those rights must be
356.35 documented in the person's coordinated service and support plan for the person and or
356.36 coordinated service and support plan addendum. The restriction must be implemented

357.1 in the least restrictive alternative manner necessary to protect the person and provide
357.2 support to reduce or eliminate the need for the restriction in the most integrated setting
357.3 and inclusive manner. The documentation must include the following information:

357.4 (1) the justification for the restriction based on an assessment of the person's
357.5 vulnerability related to exercising the right without restriction;

357.6 (2) the objective measures set as conditions for ending the restriction;

357.7 (3) a schedule for reviewing the need for the restriction based on the conditions for
357.8 ending the restriction to occur, ~~at a minimum, every three months for persons who do not~~
357.9 ~~have a legal representative and annually for persons who do have a legal representative~~
357.10 semiannually from the date of initial approval, at a minimum, or more frequently if
357.11 requested by the person, the person's legal representative, if any, and case manager; and

357.12 (4) signed and dated approval for the restriction from the person, or the person's
357.13 legal representative, if any. A restriction may be implemented only when the required
357.14 approval has been obtained. Approval may be withdrawn at any time. If approval is
357.15 withdrawn, the right must be immediately and fully restored.

357.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

357.17 Sec. 25. Minnesota Statutes 2012, section 245D.05, is amended to read:

357.18 **245D.05 HEALTH SERVICES.**

357.19 Subdivision 1. **Health needs.** (a) The license holder is responsible for ~~providing~~
357.20 meeting health services service needs assigned in the coordinated service and support plan
357.21 ~~and or the coordinated service and support plan addendum,~~ consistent with the person's
357.22 health needs. The license holder is responsible for promptly notifying ~~the person or~~
357.23 the person's legal representative, if any, and the case manager of changes in a person's
357.24 physical and mental health needs affecting ~~assigned health services~~ service needs assigned
357.25 to the license holder in the coordinated service and support plan or the coordinated service
357.26 and support plan addendum, when discovered by the license holder, unless the license
357.27 holder has reason to know the change has already been reported. The license holder
357.28 must document when the notice is provided.

357.29 (b) ~~When assigned in the service plan,~~ If responsibility for meeting the person's
357.30 health service needs has been assigned to the license holder in the coordinated service and
357.31 support plan or the coordinated service and support plan addendum, the license holder is
357.32 ~~required to~~ must maintain documentation on how the person's health needs will be met,
357.33 including a description of the procedures the license holder will follow in order to:

358.1 (1) provide medication ~~administration~~, assistance or medication assistance, or
358.2 ~~medication management~~ administration according to this chapter;

358.3 (2) monitor health conditions according to written instructions from ~~the person's~~
358.4 ~~physician~~ or a licensed health professional;

358.5 (3) assist with or coordinate medical, dental, and other health service appointments; or

358.6 (4) use medical equipment, devices, or adaptive aides or technology safely and
358.7 correctly according to written instructions from ~~the person's physician~~ or a licensed
358.8 health professional.

358.9 Subd. 1a. **Medication setup.** For the purposes of this subdivision, "medication
358.10 setup" means the arranging of medications according to instructions from the pharmacy,
358.11 the prescriber, or a licensed nurse, for later administration when the license holder
358.12 is assigned responsibility for medication assistance or medication administration in
358.13 the coordinated service and support plan or the coordinated service and support plan
358.14 addendum. A prescription label or the prescriber's written or electronically recorded order
358.15 for the prescription is sufficient to constitute written instructions from the prescriber. The
358.16 license holder must document in the person's medication administration record: dates
358.17 of setup, name of medication, quantity of dose, times to be administered, and route of
358.18 administration at time of setup; and, when the person will be away from home, to whom
358.19 the medications were given.

358.20 Subd. 1b. **Medication assistance.** If responsibility for medication assistance
358.21 is assigned to the license holder in the coordinated service and support plan or the
358.22 coordinated service and support plan addendum, the license holder must ensure that
358.23 the requirements of subdivision 2, paragraph (b), have been met when staff provides
358.24 medication assistance to enable a person to self-administer medication or treatment when
358.25 the person is capable of directing the person's own care, or when the person's legal
358.26 representative is present and able to direct care for the person. For the purposes of this
358.27 subdivision, "medication assistance" means any of the following:

358.28 (1) bringing to the person and opening a container of previously set up medications,
358.29 emptying the container into the person's hand, or opening and giving the medications in
358.30 the original container to the person;

358.31 (2) bringing to the person liquids or food to accompany the medication; or

358.32 (3) providing reminders to take regularly scheduled medication or perform regularly
358.33 scheduled treatments and exercises.

358.34 Subd. 2. **Medication administration.** (a) If responsibility for medication
358.35 administration is assigned to the license holder in the coordinated service and support plan
358.36 or the coordinated service and support plan addendum, the license holder must implement

359.1 the following medication administration procedures to ensure a person takes medications
359.2 and treatments as prescribed:

359.3 (1) checking the person's medication record;

359.4 (2) preparing the medication as necessary;

359.5 (3) administering the medication or treatment to the person;

359.6 (4) documenting the administration of the medication or treatment or the reason for
359.7 not administering the medication or treatment; and

359.8 (5) reporting to the prescriber or a nurse any concerns about the medication or
359.9 treatment, including side effects, effectiveness, or a pattern of the person refusing to
359.10 take the medication or treatment as prescribed. Adverse reactions must be immediately
359.11 reported to the prescriber or a nurse.

359.12 (b)(1) The license holder must ensure that the following criteria requirements in
359.13 clauses (2) to (4) have been met before staff that is not a licensed health professional
359.14 administers administering medication or treatment.:

359.15 (1) (2) The license holder must obtain written authorization has been obtained from
359.16 the person or the person's legal representative to administer medication or treatment
359.17 orders; and must obtain reauthorization annually as needed. If the person or the person's
359.18 legal representative refuses to authorize the license holder to administer medication, the
359.19 medication must not be administered. The refusal to authorize medication administration
359.20 must be reported to the prescriber as expeditiously as possible.

359.21 (2) (3) The staff person has completed responsible for administering the medication
359.22 or treatment must complete medication administration training according to section
359.23 245D.09, subdivision 4, paragraph 4a, paragraphs (a) and (c), clause (2); and, as applicable
359.24 to the person, paragraph (d).

359.25 (3) The medication or treatment will be administered under administration
359.26 procedures established for the person in consultation with a licensed health professional.
359.27 written instruction from the person's physician may constitute the medication
359.28 administration procedures. A prescription label or the prescriber's order for the
359.29 prescription is sufficient to constitute written instructions from the prescriber. A licensed
359.30 health professional may delegate medication administration procedures.

359.31 (4) For a license holder providing intensive support services, the medication or
359.32 treatment must be administered according to the license holder's medication administration
359.33 policy and procedures as required under section 245D.11, subdivision 2, clause (3).

359.34 (b) (c) The license holder must ensure the following information is documented in
359.35 the person's medication administration record:

360.1 (1) the information on the current prescription label or the prescriber's current written
360.2 or electronically recorded order or prescription that includes directions for the person's
360.3 name, description of the medication or treatment to be provided, and the frequency and
360.4 other information needed to safely and correctly administering administer the medication
360.5 or treatment to ensure effectiveness;

360.6 (2) information on any ~~diseomforts~~, risks; or other side effects that are reasonable to
360.7 expect, and any contraindications to its use. This information must be readily available
360.8 to all staff administering the medication;

360.9 (3) the possible consequences if the medication or treatment is not taken or
360.10 administered as directed;

360.11 (4) instruction ~~from the prescriber~~ on when and to whom to report the following:

360.12 (i) if the a dose of medication or treatment is not administered or treatment is not
360.13 performed as prescribed, whether by error by the staff or the person or by refusal by
360.14 the person; and

360.15 (ii) the occurrence of possible adverse reactions to the medication or treatment;

360.16 (5) notation of any occurrence of a dose of medication not being administered or
360.17 treatment not performed as prescribed, whether by error by the staff or the person or by
360.18 refusal by the person, or of adverse reactions, and when and to whom the report was
360.19 made; and

360.20 (6) notation of when a medication or treatment is started, administered, changed, or
360.21 discontinued.

360.22 ~~(e) The license holder must ensure that the information maintained in the medication~~
360.23 ~~administration record is current and is regularly reviewed with the person or the person's~~
360.24 ~~legal representative and the staff administering the medication to identify medication~~
360.25 ~~administration issues or errors. At a minimum, the review must be conducted every three~~
360.26 ~~months or more often if requested by the person or the person's legal representative.~~

360.27 ~~Based on the review, the license holder must develop and implement a plan to correct~~
360.28 ~~medication administration issues or errors. If issues or concerns are identified related to~~
360.29 ~~the medication itself, the license holder must report those as required under subdivision 4.~~

360.30 ~~Subd. 3. **Medication assistance.** The license holder must ensure that the~~
360.31 ~~requirements of subdivision 2, paragraph (a), have been met when staff provides assistance~~
360.32 ~~to enable a person to self-administer medication when the person is capable of directing~~
360.33 ~~the person's own care, or when the person's legal representative is present and able to~~
360.34 ~~direct care for the person.~~

360.35 Subd. 4. Reviewing and reporting medication and treatment issues. The
360.36 following medication administration issues must be reported to the person or the person's

361.1 ~~legal representative and case manager as they occur or following timelines established~~
361.2 ~~in the person's service plan or as requested in writing by the person or the person's legal~~
361.3 ~~representative, or the case manager:~~ (a) When assigned responsibility for medication
361.4 administration, the license holder must ensure that the information maintained in
361.5 the medication administration record is current and is regularly reviewed to identify
361.6 medication administration errors. At a minimum, the review must be conducted every
361.7 three months, or more frequently as directed in the coordinated service and support plan
361.8 or coordinated service and support plan addendum or as requested by the person or the
361.9 person's legal representative. Based on the review, the license holder must develop and
361.10 implement a plan to correct patterns of medication administration errors when identified.

361.11 (b) If assigned responsibility for medication assistance or medication administration,
361.12 the license holder must report the following to the person's legal representative and case
361.13 manager as they occur or as otherwise directed in the coordinated service and support plan
361.14 or the coordinated service and support plan addendum:

361.15 (1) any reports made to the person's physician or prescriber required under
361.16 subdivision 2, paragraph ~~(b)~~ (c), clause (4);

361.17 (2) a person's refusal or failure to take or receive medication or treatment as
361.18 prescribed; or

361.19 (3) concerns about a person's self-administration of medication or treatment.

361.20 Subd. 5. **Injectable medications.** Injectable medications may be administered
361.21 according to a prescriber's order and written instructions when one of the following
361.22 conditions has been met:

361.23 (1) a registered nurse or licensed practical nurse will administer the subcutaneous or
361.24 intramuscular injection;

361.25 (2) a supervising registered nurse with a physician's order has delegated the
361.26 administration of subcutaneous injectable medication to an unlicensed staff member
361.27 and has provided the necessary training; or

361.28 (3) there is an agreement signed by the license holder, the prescriber, and the
361.29 person or the person's legal representative specifying what subcutaneous injections may
361.30 be given, when, how, and that the prescriber must retain responsibility for the license
361.31 holder's giving the injections. A copy of the agreement must be placed in the person's
361.32 service recipient record.

361.33 Only licensed health professionals are allowed to administer psychotropic
361.34 medications by injection.

361.35 **EFFECTIVE DATE.** This section is effective January 1, 2014.

362.1 Sec. 26. **[245D.051] PSYCHOTROPIC MEDICATION USE AND**
362.2 **MONITORING.**

362.3 Subdivision 1. **Conditions for psychotropic medication administration.** (a)
362.4 When a person is prescribed a psychotropic medication and the license holder is assigned
362.5 responsibility for administration of the medication in the person's coordinated service
362.6 and support plan or the coordinated service and support plan addendum, the license
362.7 holder must ensure that the requirements in paragraphs (b) to (d) and section 245D.05,
362.8 subdivision 2, are met.

362.9 (b) Use of the medication must be included in the person's coordinated service and
362.10 support plan or in the coordinated service and support plan addendum and based on a
362.11 prescriber's current written or electronically recorded prescription.

362.12 (c) The license holder must develop, implement, and maintain the following
362.13 documentation in the person's coordinated service and support plan addendum according
362.14 to the requirements in sections 245D.07 and 245D.071:

362.15 (1) a description of the target symptoms that the psychotropic medication is to
362.16 alleviate; and

362.17 (2) documentation methods the license holder will use to monitor and measure
362.18 changes in the target symptoms that are to be alleviated by the psychotropic medication if
362.19 required by the prescriber. The license holder must collect and report on medication and
362.20 symptom-related data as instructed by the prescriber. The license holder must provide
362.21 the monitoring data to the expanded support team for review every three months, or as
362.22 otherwise requested by the person or the person's legal representative.

362.23 For the purposes of this section, "target symptom" refers to any perceptible
362.24 diagnostic criteria for a person's diagnosed mental disorder as defined by the Diagnostic
362.25 and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) or
362.26 successive editions that has been identified for alleviation.

362.27 Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the
362.28 person's legal representative refuses to authorize the administration of a psychotropic
362.29 medication as ordered by the prescriber, the license holder must follow the requirement
362.30 in section 245D.05, subdivision 2, paragraph (b), clause (2). After reporting the refusal
362.31 to the prescriber, the license holder must follow any directives or orders given by the
362.32 prescriber. A court order must be obtained to override the refusal. Refusal to authorize
362.33 administration of a specific psychotropic medication is not grounds for service termination
362.34 and does not constitute an emergency. A decision to terminate services must be reached in
362.35 compliance with section 245D.10, subdivision 3.

362.36 **EFFECTIVE DATE.** This section is effective January 1, 2014.

363.1 Sec. 27. Minnesota Statutes 2012, section 245D.06, is amended to read:

363.2 **245D.06 PROTECTION STANDARDS.**

363.3 Subdivision 1. **Incident response and reporting.** (a) The license holder must
363.4 respond to ~~all~~ incidents under section 245D.02, subdivision 11, that occur while providing
363.5 services to protect the health and safety of and minimize risk of harm to the person.

363.6 (b) The license holder must maintain information about and report incidents to the
363.7 person's legal representative or designated emergency contact and case manager within 24
363.8 hours of an incident occurring while services are being provided, ~~or~~ within 24 hours of
363.9 discovery or receipt of information that an incident occurred, unless the license holder
363.10 has reason to know that the incident has already been reported, or as otherwise directed
363.11 in a person's coordinated service and support plan or coordinated service and support
363.12 plan addendum. An incident of suspected or alleged maltreatment must be reported as
363.13 required under paragraph (d), and an incident of serious injury or death must be reported
363.14 as required under paragraph (e).

363.15 (c) When the incident involves more than one person, the license holder must not
363.16 disclose personally identifiable information about any other person when making the report
363.17 to each person and case manager unless the license holder has the consent of the person.

363.18 (d) Within 24 hours of reporting maltreatment as required under section 626.556
363.19 or 626.557, the license holder must inform the case manager of the report unless there is
363.20 reason to believe that the case manager is involved in the suspected maltreatment. The
363.21 license holder must disclose the nature of the activity or occurrence reported and the
363.22 agency that received the report.

363.23 (e) The license holder must report the death or serious injury of the person ~~to the legal~~
363.24 ~~representative, if any, and case manager,~~ as required in paragraph (b) and to the Department
363.25 of Human Services Licensing Division, and the Office of Ombudsman for Mental Health
363.26 and Developmental Disabilities as required under section 245.94, subdivision 2a, within
363.27 24 hours of the death, or receipt of information that the death occurred, unless the license
363.28 holder has reason to know that the death has already been reported.

363.29 (f) When a death or serious injury occurs in a facility certified as an intermediate
363.30 care facility for persons with developmental disabilities, the death or serious injury must
363.31 be reported to the Department of Health, Office of Health Facility Complaints, and the
363.32 Office of Ombudsman for Mental Health and Developmental Disabilities, as required
363.33 under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to
363.34 know that the death has already been reported.

363.35 (f) (g) The license holder must conduct a an internal review of incident reports of
363.36 deaths and serious injuries that occurred while services were being provided and that

364.1 were not reported by the program as alleged or suspected maltreatment, for identification
364.2 of incident patterns, and implementation of corrective action as necessary to reduce
364.3 occurrences. The review must include an evaluation of whether related policies and
364.4 procedures were followed, whether the policies and procedures were adequate, whether
364.5 there is a need for additional staff training, whether the reported event is similar to past
364.6 events with the persons or the services involved, and whether there is a need for corrective
364.7 action by the license holder to protect the health and safety of persons receiving services.
364.8 Based on the results of this review, the license holder must develop, document, and
364.9 implement a corrective action plan designed to correct current lapses and prevent future
364.10 lapses in performance by staff or the license holder, if any.

364.11 (h) The license holder must verbally report the emergency use of manual restraint of
364.12 a person as required in paragraph (b), within 24 hours of the occurrence. The license holder
364.13 must ensure the written report and internal review of all incident reports of the emergency
364.14 use of manual restraints are completed according to the requirements in section 245D.061.

364.15 Subd. 2. **Environment and safety.** The license holder must:

364.16 (1) ensure the following when the license holder is the owner, lessor, or tenant
364.17 of the service site:

364.18 (i) the service site is a safe and hazard-free environment;

364.19 (ii) ~~doors are locked or that~~ toxic substances or dangerous items ~~normally accessible~~
364.20 are inaccessible to persons served by the program ~~are stored in locked cabinets, drawers, or~~
364.21 ~~containers~~ only to protect the safety of a person receiving services and not as a substitute
364.22 for staff supervision or interactions with a person who is receiving services. ~~If doors are~~
364.23 ~~locked or~~ toxic substances or dangerous items ~~normally accessible to persons served by the~~
364.24 ~~program are stored in locked cabinets, drawers, or containers~~ are made inaccessible, the
364.25 license holder must ~~justify and document how this determination was made in consultation~~
364.26 ~~with the person or person's legal representative, and how access will otherwise be provided~~
364.27 ~~to the person and all other affected persons receiving services; and~~ document an assessment
364.28 of the physical plant, its environment, and its population identifying the risk factors which
364.29 require toxic substances or dangerous items to be inaccessible and a statement of specific
364.30 measures to be taken to minimize the safety risk to persons receiving services;

364.31 (iii) doors are locked from the inside to prevent a person from exiting only when
364.32 necessary to protect the safety of a person receiving services and not as a substitute for
364.33 staff supervision or interactions with the person. If doors are locked from the inside, the
364.34 license holder must document an assessment of the physical plant, the environment and
364.35 the population served, identifying the risk factors which require the use of locked doors,

365.1 and a statement of specific measures to be taken to minimize the safety risk to persons
365.2 receiving services at the service site; and

365.3 ~~(iii)~~ (iv) a staff person is available on at the service site who is trained in basic first
365.4 aid and, when required in a person's coordinated service and support plan or coordinated
365.5 service and support plan addendum, cardiopulmonary resuscitation, "CPR," whenever
365.6 persons are present and staff are required to be at the site to provide direct service. The
365.7 CPR training must include in-person instruction, hands-on practice, and an observed skills
365.8 assessment under the direct supervision of a CPR instructor;

365.9 (2) maintain equipment, vehicles, supplies, and materials owned or leased by the
365.10 license holder in good condition when used to provide services;

365.11 (3) follow procedures to ensure safe transportation, handling, and transfers of the
365.12 person and any equipment used by the person, when the license holder is responsible for
365.13 transportation of a person or a person's equipment;

365.14 (4) be prepared for emergencies and follow emergency response procedures to
365.15 ensure the person's safety in an emergency; and

365.16 (5) follow universal precautions and sanitary practices, including hand washing, for
365.17 infection prevention and control, and to prevent communicable diseases.

365.18 ~~Subd. 3. **Compliance with fire and safety codes.** When services are provided at a~~
365.19 ~~service site licensed according to chapter 245A or where the license holder is the owner,~~
365.20 ~~lessor, or tenant of the service site, the license holder must document compliance with~~
365.21 ~~applicable building codes, fire and safety codes, health rules, and zoning ordinances, or~~
365.22 ~~document that an appropriate waiver has been granted.~~

365.23 Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person
365.24 with the safekeeping of funds or other property according to section 245A.04, subdivision
365.25 13, the license holder must ~~have~~ obtain written authorization to do so from the person or
365.26 the person's legal representative and the case manager. Authorization must be obtained
365.27 within five working days of service initiation and renewed annually thereafter. At the time
365.28 initial authorization is obtained, the license holder must survey, document, and implement
365.29 the preferences of the person or the person's legal representative and the case manager
365.30 for frequency of receiving a statement that itemizes receipts and disbursements of funds
365.31 or other property. The license holder must document changes to these preferences when
365.32 they are requested.

365.33 (b) A license holder or staff person may not accept powers-of-attorney from a
365.34 person receiving services from the license holder for any purpose, ~~and may not accept an~~
365.35 ~~appointment as guardian or conservator of a person receiving services from the license~~
365.36 ~~holder.~~ This does not apply to license holders that are Minnesota counties or other

366.1 units of government or to staff persons employed by license holders who were acting
366.2 as ~~power-of-attorney, guardian, or conservator~~ attorney-in-fact for specific individuals
366.3 prior to ~~April 23, 2012~~ implementation of this chapter. The license holder must maintain
366.4 documentation of the ~~power-of-attorney, guardianship, or conservatorship~~ in the service
366.5 recipient record.

366.6 (c) Upon the transfer or death of a person, any funds or other property of the person
366.7 must be surrendered to the person or the person's legal representative, or given to the
366.8 executor or administrator of the estate in exchange for an itemized receipt.

366.9 Subd. 5. **Prohibitions Prohibited procedures.** (a) The license holder is prohibited
366.10 from using ~~psychotropic medication~~ chemical restraints, mechanical restraints, manual
366.11 restraints, time out, seclusion, or any other aversive or deprivation procedure, as a
366.12 substitute for adequate staffing, for a behavioral or therapeutic program to reduce or
366.13 eliminate behavior, as punishment, or for staff convenience, ~~or for any reason other than~~
366.14 ~~as prescribed~~.

366.15 ~~(b) The license holder is prohibited from using restraints or seclusion under any~~
366.16 ~~circumstance, unless the commissioner has approved a variance request from the license~~
366.17 ~~holder that allows for the emergency use of restraints and seclusion according to terms~~
366.18 ~~and conditions approved in the variance. Applicants and license holders who have~~
366.19 ~~reason to believe they may be serving an individual who will need emergency use of~~
366.20 ~~restraints or seclusion may request a variance on the application or reapplication, and~~
366.21 ~~the commissioner shall automatically review the request for a variance as part of the~~
366.22 ~~application or reapplication process. License holders may also request the variance any~~
366.23 ~~time after issuance of a license. In the event a license holder uses restraint or seclusion for~~
366.24 ~~any reason without first obtaining a variance as required, the license holder must report~~
366.25 ~~the unauthorized use of restraint or seclusion to the commissioner within 24 hours of the~~
366.26 ~~occurrence and request the required variance.~~

366.27 Subd. 6. **Restricted procedures.** The following procedures are allowed when the
366.28 procedures are implemented in compliance with the standards governing their use as
366.29 identified in clauses (1) to (3). Allowed but restricted procedures include:

366.30 (1) permitted actions and procedures subject to the requirements in subdivision 7;

366.31 (2) procedures identified in a positive support transition plan subject to the
366.32 requirements in subdivision 8; or

366.33 (3) emergency use of manual restraint subject to the requirements in section
366.34 245D.061.

366.35 For purposes of this chapter, this section supersedes the requirements identified in
366.36 Minnesota Rules, part 9525.2740.

367.1 Subd. 7. Permitted actions and procedures. (a) Use of the instructional techniques
367.2 and intervention procedures as identified in paragraphs (b) and (c), is permitted when used
367.3 on an intermittent or continuous basis. When used on a continuous basis, it must be
367.4 addressed in a person's coordinated service and support plan addendum as identified in
367.5 sections 245D.07 and 245D.071. For purposes of this chapter, the requirements of this
367.6 subdivision supersede the requirements identified in Minnesota Rules, part 9525.2720.

367.7 (b) Physical contact or instructional techniques must use the least restrictive
367.8 alternative possible to meet the needs of the person and may be used:

367.9 (1) to calm or comfort a person by holding that person with no resistance from
367.10 that person;

367.11 (2) to protect a person known to be at risk or injury due to frequent falls as a result
367.12 of a medical condition;

367.13 (3) to facilitate the person's completion of a task or response when the person does
367.14 not resist or the person's resistance is minimal in intensity and duration; or

367.15 (4) to briefly block or redirect a person's limbs or body without holding the person
367.16 or limiting the person's movement to interrupt the person's behavior that may result in
367.17 injury to self or others.

367.18 (c) Restraint may be used as an intervention procedure to:

367.19 (1) allow a licensed health care professional to safely conduct a medical examination
367.20 or to provide medical treatment ordered by a licensed health care professional to a person
367.21 necessary to promote healing or recovery from an acute, meaning short-term, medical
367.22 condition;

367.23 (2) assist in the safe evacuation or redirection of a person in the event of an
367.24 emergency and the person is at imminent risk of harm.

367.25 Any use of manual restraint as allowed in this paragraph must comply with the restrictions
367.26 identified in section 245D.061, subdivision 3; or

367.27 (3) to position a person with physical disabilities in a manner specified in the
367.28 person's coordinated service and support plan addendum.

367.29 (d) Use of adaptive aids or equipment, orthotic devices, or other medical equipment
367.30 ordered by a licensed health professional to treat a diagnosed medical condition do not in
367.31 and of themselves constitute the use of mechanical restraint.

367.32 Subd. 8. Positive support transition plan. License holders must develop a positive
367.33 support transition plan on the forms and in the manner prescribed by the commissioner for
367.34 a person who requires intervention in order to maintain safety when it is known that the
367.35 person's behavior poses an immediate risk of physical harm to self or others. The positive
367.36 support transition plan forms and instructions will supersede the requirements in Minnesota

368.1 Rules, parts 9525.2750; 9525.2760; and 9525.2780. The positive support transition plan
368.2 must phase out any existing plans for the emergency or programmatic use of aversive or
368.3 deprivation procedures prohibited under this chapter within the following timelines:

368.4 (1) for persons receiving services from the license holder before January 1, 2014,
368.5 the plan must be developed and implemented by February 1, 2014, and phased out no
368.6 later than December 31, 2014; and

368.7 (2) for persons admitted to the program on or after January 1, 2014, the plan must be
368.8 developed and implemented within 30 calendar days of service initiation and phased out
368.9 no later than 11 months from the date of plan implementation.

368.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

368.11 Sec. 28. **[245D.061] EMERGENCY USE OF MANUAL RESTRAINTS.**

368.12 Subdivision 1. Standards for emergency use of manual restraints. The license
368.13 holder must ensure that emergency use of manual restraints complies with the requirements
368.14 of this chapter and the license holder's policy and procedures as required under subdivision
368.15 10. For the purposes of persons receiving services governed by this chapter, this section
368.16 supersedes the requirements identified in Minnesota Rules, part 9525.2770.

368.17 Subd. 2. Conditions for emergency use of manual restraint. Emergency use of
368.18 manual restraint must meet the following conditions:

368.19 (1) immediate intervention must be needed to protect the person or others from
368.20 imminent risk of physical harm; and

368.21 (2) the type of manual restraint used must be the least restrictive intervention to
368.22 eliminate the immediate risk of harm and effectively achieve safety. The manual restraint
368.23 must end when the threat of harm ends.

368.24 Subd. 3. Restrictions when implementing emergency use of manual restraint.

368.25 (a) Emergency use of manual restraint procedures must not:

368.26 (1) be implemented with a child in a manner that constitutes sexual abuse, neglect,
368.27 physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

368.28 (2) be implemented with an adult in a manner that constitutes abuse or neglect as
368.29 defined in section 626.5572, subdivisions 2 and 17;

368.30 (3) be implemented in a manner that violates a person's rights and protections
368.31 identified in section 245D.04;

368.32 (4) restrict a person's normal access to a nutritious diet, drinking water, adequate
368.33 ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping
368.34 conditions, or necessary clothing, or to any protection required by state licensing standards
368.35 and federal regulations governing the program;

369.1 (5) deny the person visitation or ordinary contact with legal counsel, a legal
369.2 representative, or next of kin;

369.3 (6) be used as a substitute for adequate staffing, for the convenience of staff, as
369.4 punishment, or as a consequence if the person refuses to participate in the treatment
369.5 or services provided by the program; or

369.6 (7) use prone restraint. For the purposes of this section, "prone restraint" means use
369.7 of manual restraint that places a person in a face-down position. This does not include
369.8 brief physical holding of a person who, during an emergency use of manual restraint, rolls
369.9 into a prone position, and the person is restored to a standing, sitting, or side-lying position
369.10 as quickly as possible. Applying back or chest pressure while a person is in the prone or
369.11 supine position or face-up is prohibited.

369.12 Subd. 4. **Monitoring emergency use of manual restraint.** The license holder shall
369.13 monitor a person's health and safety during an emergency use of a manual restraint. Staff
369.14 monitoring the procedure must not be the staff implementing the procedure when possible.
369.15 The license holder shall complete a monitoring form, approved by the commissioner, for
369.16 each incident involving the emergency use of a manual restraint.

369.17 Subd. 5. **Reporting emergency use of manual restraint incident.** (a) Within
369.18 three calendar days after an emergency use of a manual restraint, the staff person who
369.19 implemented the emergency use must report in writing to the designated coordinator the
369.20 following information about the emergency use:

369.21 (1) the staff and persons receiving services who were involved in the incident
369.22 leading up to the emergency use of manual restraint;

369.23 (2) a description of the physical and social environment, including who was present
369.24 before and during the incident leading up to the emergency use of manual restraint;

369.25 (3) a description of what less restrictive alternative measures were attempted to
369.26 de-escalate the incident and maintain safety before the manual restraint was implemented
369.27 that identifies when, how, and how long the alternative measures were attempted before
369.28 manual restraint was implemented;

369.29 (4) a description of the mental, physical, and emotional condition of the person who
369.30 was restrained, and other persons involved in the incident leading up to, during, and
369.31 following the manual restraint;

369.32 (5) whether there was any injury to the person who was restrained or other persons
369.33 involved in the incident, including staff, before or as a result of the use of manual restraint;

369.34 (6) whether there was a debriefing with the staff, and, if not contraindicated, with
369.35 the person who was restrained and other persons who were involved in or who witnessed
369.36 the restraint, following the incident and the outcome of the debriefing. If the debriefing

370.1 was not conducted at the time the incident report was made, the report should identify
370.2 whether a debriefing is planned; and

370.3 (7) a copy of the report must be maintained in the person's service recipient record.

370.4 (b) Each single incident of emergency use of manual restraint must be reported
370.5 separately. For the purposes of this subdivision, an incident of emergency use of manual
370.6 restraint is a single incident when the following conditions have been met:

370.7 (1) after implementing the manual restraint, staff attempt to release the person at the
370.8 moment staff believe the person's conduct no longer poses an imminent risk of physical
370.9 harm to self or others and less restrictive strategies can be implemented to maintain safety;

370.10 (2) upon the attempt to release the restraint, the person's behavior immediately
370.11 re-escalates; and

370.12 (3) staff must immediately reimplement the restraint in order to maintain safety.

370.13 Subd. 6. **Internal review of emergency use of manual restraint.** (a) Within five
370.14 working days of the emergency use of manual restraint, the license holder must complete
370.15 and document an internal review of each report of emergency use of manual restraint. The
370.16 review must include an evaluation of whether:

370.17 (1) the person's service and support strategies developed according to sections
370.18 245D.07 and 245D.071 need to be revised;

370.19 (2) related policies and procedures were followed;

370.20 (3) the policies and procedures were adequate;

370.21 (4) there is a need for additional staff training;

370.22 (5) the reported event is similar to past events with the persons, staff, or the services
370.23 involved; and

370.24 (6) there is a need for corrective action by the license holder to protect the health
370.25 and safety of persons.

370.26 (b) Based on the results of the internal review, the license holder must develop,
370.27 document, and implement a corrective action plan for the program designed to correct
370.28 current lapses and prevent future lapses in performance by individuals or the license
370.29 holder, if any. The corrective action plan, if any, must be implemented within 30 days of
370.30 the internal review being completed.

370.31 (c) The license holder must maintain a copy of the internal review and the corrective
370.32 action plan, if any, in the person's service recipient record.

370.33 Subd. 7. **Expanded support team review.** (a) Within five working days after the
370.34 completion of the internal review required in subdivision 8, the license holder must consult
370.35 with the expanded support team following the emergency use of manual restraint to:

371.1 (1) discuss the incident reported in subdivision 7, to define the antecedent or event
371.2 that gave rise to the behavior resulting in the manual restraint and identify the perceived
371.3 function the behavior served; and

371.4 (2) determine whether the person's coordinated service and support plan addendum
371.5 needs to be revised according to sections 245D.07 and 245D.071 to positively and
371.6 effectively help the person maintain stability and to reduce or eliminate future occurrences
371.7 requiring emergency use of manual restraint.

371.8 (b) The license holder must maintain a written summary of the expanded support
371.9 team's discussion and decisions required in paragraph (a) in the person's service recipient
371.10 record.

371.11 Subd. 8. **External review and reporting.** Within five working days of the expanded
371.12 support team review, the license holder must submit the following to the Department of
371.13 Human Services, and the Office of the Ombudsman for Mental Health and Developmental
371.14 Disabilities, as required under section 245.94, subdivision 2a:

371.15 (1) the report required under subdivision 7;

371.16 (2) the internal review and the corrective action plan required under subdivision 8; and

371.17 (3) the summary of the expanded support team review required under subdivision 9.

371.18 Subd. 9. **Emergency use of manual restraints policy and procedures.** The license
371.19 holder must develop, document, and implement a policy and procedures that promote
371.20 service recipient rights and protect health and safety during the emergency use of manual
371.21 restraints. The policy and procedures must comply with the requirements of this section
371.22 and must specify the following:

371.23 (1) a description of the positive support strategies and techniques staff must use to
371.24 attempt to de-escalate a person's behavior before it poses an imminent risk of physical
371.25 harm to self or others;

371.26 (2) a description of the types of manual restraints the license holder allows staff to
371.27 use on an emergency basis, if any. If the license holder will not allow the emergency use
371.28 of manual restraint, the policy and procedure must identify the alternative measures the
371.29 license holder will require staff to use when a person's conduct poses an imminent risk of
371.30 physical harm to self or others and less restrictive strategies would not achieve safety;

371.31 (3) instructions for safe and correct implementation of the allowed manual restraint
371.32 procedures;

371.33 (4) the training that staff must complete and the timelines for completion, before they
371.34 may implement an emergency use of manual restraint. In addition to the training on this
371.35 policy and procedure and the orientation and annual training required in section 245D.09,

372.1 subdivision 4, the training for emergency use of manual restraint must incorporate the
372.2 following subjects:

372.3 (i) alternatives to manual restraint procedures, including techniques to identify
372.4 events and environmental factors that may escalate conduct that poses an imminent risk of
372.5 physical harm to self or others;

372.6 (ii) de-escalation methods, positive support strategies, and how to avoid power
372.7 struggles;

372.8 (iii) simulated experiences of administering and receiving manual restraint
372.9 procedures allowed by the license holder on an emergency basis;

372.10 (iv) how to properly identify thresholds for implementing and ceasing restrictive
372.11 procedures;

372.12 (v) how to recognize, monitor, and respond to the person's physical signs of distress,
372.13 including positional asphyxia;

372.14 (vi) the physiological and psychological impact on the person and the staff when
372.15 restrictive procedures are used;

372.16 (vii) the communicative intent of behaviors; and

372.17 (viii) relationship building;

372.18 (5) the procedures and forms to be used to monitor the emergency use of manual
372.19 restraints, including what must be monitored and the frequency of monitoring per
372.20 each incident of emergency use of manual restraint, and the person or position who is
372.21 responsible for monitoring the use;

372.22 (6) the instructions, forms, and timelines required for completing and submitting an
372.23 incident report by the person or persons who implemented the manual restraint; and

372.24 (7) the procedures and timelines for conducting the internal review and the expanded
372.25 support team review, and the person or position responsible for completing the reviews
372.26 and for ensuring that corrective action is taken or the person's coordinated service and
372.27 support plan addendum is revised, when determined necessary.

372.28 **EFFECTIVE DATE.** This section is effective January 1, 2014.

372.29 Sec. 29. Minnesota Statutes 2012, section 245D.07, is amended to read:

372.30 **245D.07 SERVICE NEEDS PLANNING AND DELIVERY.**

372.31 Subdivision 1. **Provision of services.** The license holder must provide services as
372.32 ~~specified assigned~~ in the coordinated service and support plan ~~and assigned to the license~~
372.33 ~~holder.~~ The provision of services must comply with the requirements of this chapter and
372.34 the federal waiver plans.

373.1 Subd. 1a. **Person-centered planning and service delivery.** (a) The license holder
373.2 must provide services in response to the person's identified needs, interests, preferences,
373.3 and desired outcomes as specified in the coordinated service and support plan and the
373.4 coordinated service and support plan addendum, and in compliance with the requirements
373.5 of this chapter. License holders providing intensive support services must also provide
373.6 outcome-based services according to the requirements in section 245D.071.

373.7 (b) Services must be provided in a manner that supports the person's preferences,
373.8 daily needs, and activities and accomplishment of the person's personal goals and service
373.9 outcomes, consistent with the principles of:

373.10 (1) person-centered service planning and delivery that:

373.11 (i) identifies and supports what is important to the person as well as what is
373.12 important for the person, including preferences for when, how, and by whom direct
373.13 support service is provided;

373.14 (ii) uses that information to identify outcomes the person desires; and

373.15 (iii) respects each person's history, dignity, and cultural background;

373.16 (2) self-determination that supports and provides:

373.17 (i) opportunities for the development and exercise of functional and age-appropriate
373.18 skills, decision making and choice, personal advocacy, and communication; and

373.19 (ii) the affirmation and protection of each person's civil and legal rights; and

373.20 (3) providing the most integrated setting and inclusive service delivery that supports,
373.21 promotes, and allows:

373.22 (i) inclusion and participation in the person's community as desired by the person
373.23 in a manner that enables the person to interact with nondisabled persons to the fullest
373.24 extent possible and supports the person in developing and maintaining a role as a valued
373.25 community member;

373.26 (ii) opportunities for self-sufficiency as well as developing and maintaining social
373.27 relationships and natural supports; and

373.28 (iii) a balance between risk and opportunity, meaning the least restrictive supports or
373.29 interventions necessary are provided in the most integrated settings in the most inclusive
373.30 manner possible to support the person to engage in activities of the person's own choosing
373.31 that may otherwise present a risk to the person's health, safety, or rights.

373.32 Subd. 2. **Service planning requirements for basic support services.** (a) License
373.33 holders providing basic support services must meet the requirements of this subdivision.

373.34 (b) Within 15 days of service initiation the license holder must complete a
373.35 preliminary coordinated service and support plan addendum based on the coordinated
373.36 service and support plan.

374.1 (c) Within 60 days of service initiation the license holder must review and revise as
374.2 needed the preliminary coordinated service and support plan addendum to document the
374.3 services that will be provided including how, when, and by whom services will be provided,
374.4 and the person responsible for overseeing the delivery and coordination of services.

374.5 (d) The license holder must participate in service planning and support team
374.6 meetings related to for the person following stated timelines established in the person's
374.7 coordinated service and support plan or as requested by the support team, the person, or
374.8 the person's legal representative, the support team or the expanded support team.

374.9 Subd. 3. **Reports.** The license holder must provide written reports regarding the
374.10 person's progress or status as requested by the person, the person's legal representative, the
374.11 case manager, or the team.

374.12 **EFFECTIVE DATE.** This section is effective January 1, 2014.

374.13 Sec. 30. **[245D.071] SERVICE PLANNING AND DELIVERY; INTENSIVE**
374.14 **SUPPORT SERVICES.**

374.15 Subdivision 1. Requirements for intensive support services. A license holder
374.16 providing intensive support services identified in section 245D.03, subdivision 1,
374.17 paragraph (c), must comply with the requirements in section 245D.07, subdivisions 1
374.18 and 3, and this section.

374.19 Subd. 2. Abuse prevention. Prior to or upon initiating services, the license holder
374.20 must develop, document, and implement an abuse prevention plan according to section
374.21 245A.65, subdivision 2.

374.22 Subd. 3. Assessment and initial service planning. (a) Within 15 days of service
374.23 initiation the license holder must complete a preliminary coordinated service and support
374.24 plan addendum based on the coordinated service and support plan.

374.25 (b) Within 45 days of service initiation the license holder must meet with the person,
374.26 the person's legal representative, the case manager, and other members of the support team
374.27 or expanded support team to assess and determine the following based on the person's
374.28 coordinated service and support plan and the requirements in subdivision 4 and section
374.29 245D.07, subdivision 1a:

374.30 (1) the scope of the services to be provided to support the person's daily needs
374.31 and activities;

374.32 (2) the person's desired outcomes and the supports necessary to accomplish the
374.33 person's desired outcomes;

374.34 (3) the person's preferences for how services and supports are provided;

375.1 (4) whether the current service setting is the most integrated setting available and
375.2 appropriate for the person; and

375.3 (5) how services must be coordinated across other providers licensed under this
375.4 chapter serving the same person to ensure continuity of care for the person.

375.5 (c) Within the scope of services, the license holder must, at a minimum, assess
375.6 the following areas:

375.7 (1) the person's ability to self-manage health and medical needs to maintain or
375.8 improve physical, mental, and emotional well-being, including, when applicable, allergies,
375.9 seizures, choking, special dietary needs, chronic medical conditions, self-administration
375.10 of medication or treatment orders, preventative screening, and medical and dental
375.11 appointments;

375.12 (2) the person's ability to self-manage personal safety to avoid injury or accident in
375.13 the service setting, including, when applicable, risk of falling, mobility, regulating water
375.14 temperature, community survival skills, water safety skills, and sensory disabilities; and

375.15 (3) the person's ability to self-manage symptoms or behavior that may otherwise
375.16 result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to
375.17 (7), suspension or termination of services by the license holder, or other symptoms
375.18 or behaviors that may jeopardize the health and safety of the person or others. The
375.19 assessments must produce information about the person that is descriptive of the person's
375.20 overall strengths, functional skills and abilities, and behaviors or symptoms.

375.21 Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the
375.22 45-day meeting, the license holder must develop and document the service outcomes and
375.23 supports based on the assessments completed under subdivision 3 and the requirements
375.24 in section 245D.07, subdivision 1a. The outcomes and supports must be included in the
375.25 coordinated service and support plan addendum.

375.26 (b) The license holder must document the supports and methods to be implemented
375.27 to support the accomplishment of outcomes related to acquiring, retaining, or improving
375.28 skills. The documentation must include:

375.29 (1) the methods or actions that will be used to support the person and to accomplish
375.30 the service outcomes, including information about:

375.31 (i) any changes or modifications to the physical and social environments necessary
375.32 when the service supports are provided;

375.33 (ii) any equipment and materials required; and

375.34 (iii) techniques that are consistent with the person's communication mode and
375.35 learning style;

376.1 (2) the measurable and observable criteria for identifying when the desired outcome
376.2 has been achieved and how data will be collected;

376.3 (3) the projected starting date for implementing the supports and methods and
376.4 the date by which progress towards accomplishing the outcomes will be reviewed and
376.5 evaluated; and

376.6 (4) the names of the staff or position responsible for implementing the supports
376.7 and methods.

376.8 (c) Within 20 working days of the 45-day meeting, the license holder must obtain
376.9 dated signatures from the person or the person's legal representative and case manager
376.10 to document completion and approval of the assessment and coordinated service and
376.11 support plan addendum.

376.12 Subd. 5. **Progress reviews.** (a) The license holder must give the person or the
376.13 person's legal representative and case manager an opportunity to participate in the ongoing
376.14 review and development of the methods used to support the person and accomplish
376.15 outcomes identified in subdivisions 3 and 4. The license holder, in coordination with
376.16 the person's support team or expanded support team, must meet with the person, the
376.17 person's legal representative, and the case manager, and participate in progress review
376.18 meetings following stated timelines established in the person's coordinated service and
376.19 support plan or coordinated service and support plan addendum or within 30 days of a
376.20 written request by the person, the person's legal representative, or the case manager,
376.21 at a minimum of once per year.

376.22 (b) The license holder must summarize the person's progress toward achieving the
376.23 identified outcomes and make recommendations and identify the rationale for changing,
376.24 continuing, or discontinuing implementation of supports and methods identified in
376.25 subdivision 4 in a written report sent to the person or the person's legal representative
376.26 and case manager five working days prior to the review meeting, unless the person, the
376.27 person's legal representative, or the case manager requests to receive the report at the
376.28 time of the meeting.

376.29 (c) Within ten working days of the progress review meeting, the license holder
376.30 must obtain dated signatures from the person or the person's legal representative and
376.31 the case manager to document approval of any changes to the coordinated service and
376.32 support plan addendum.

376.33 **EFFECTIVE DATE.** This section is effective January 1, 2014.

376.34 Sec. 31. **[245D.081] PROGRAM COORDINATION, EVALUATION, AND**
376.35 **OVERSIGHT.**

377.1 Subdivision 1. **Program coordination and evaluation.** (a) The license holder
377.2 is responsible for:

377.3 (1) coordination of service delivery and evaluation for each person served by the
377.4 program as identified in subdivision 2; and

377.5 (2) program management and oversight that includes evaluation of the program
377.6 quality and program improvement for services provided by the license holder as identified
377.7 in subdivision 3.

377.8 (b) The same person may perform the functions in paragraph (a) if the work and
377.9 education qualifications are met in subdivisions 2 and 3.

377.10 Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery
377.11 and evaluation of services provided by the license holder must be coordinated by a
377.12 designated staff person. The designated coordinator must provide supervision, support,
377.13 and evaluation of activities that include:

377.14 (1) oversight of the license holder's responsibilities assigned in the person's
377.15 coordinated service and support plan and the coordinated service and support plan
377.16 addendum;

377.17 (2) taking the action necessary to facilitate the accomplishment of the outcomes
377.18 according to the requirements in section 245D.07;

377.19 (3) instruction and assistance to direct support staff implementing the coordinated
377.20 service and support plan and the service outcomes, including direct observation of service
377.21 delivery sufficient to assess staff competency; and

377.22 (4) evaluation of the effectiveness of service delivery, methodologies, and progress on
377.23 the person's outcomes based on the measurable and observable criteria for identifying when
377.24 the desired outcome has been achieved according to the requirements in section 245D.07.

377.25 (b) The license holder must ensure that the designated coordinator is competent to
377.26 perform the required duties identified in paragraph (a) through education and training in
377.27 human services and disability-related fields, and work experience in providing direct care
377.28 services and supports to persons with disabilities. The designated coordinator must have
377.29 the skills and ability necessary to develop effective plans and to design and use data
377.30 systems to measure effectiveness of services and supports. The license holder must verify
377.31 and document competence according to the requirements in section 245D.09, subdivision
377.32 3. The designated coordinator must minimally have:

377.33 (1) a baccalaureate degree in a field related to human services, and one year of
377.34 full-time work experience providing direct care services to persons with disabilities or
377.35 persons age 65 and older;

378.1 (2) an associate degree in a field related to human services, and two years of
378.2 full-time work experience providing direct care services to persons with disabilities or
378.3 persons age 65 and older;

378.4 (3) a diploma in a field related to human services from an accredited postsecondary
378.5 institution and three years of full-time work experience providing direct care services to
378.6 persons with disabilities or persons age 65 and older; or

378.7 (4) a minimum of 50 hours of education and training related to human services
378.8 and disabilities; and

378.9 (5) four years of full-time work experience providing direct care services to persons
378.10 with disabilities or persons age 65 and older under the supervision of a staff person who
378.11 meets the qualifications identified in clauses (1) to (3).

378.12 Subd. 3. **Program management and oversight.** (a) The license holder must
378.13 designate a managerial staff person or persons to provide program management and
378.14 oversight of the services provided by the license holder. The designated manager is
378.15 responsible for the following:

378.16 (1) maintaining a current understanding of the licensing requirements sufficient to
378.17 ensure compliance throughout the program as identified in section 245A.04, subdivision
378.18 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21,
378.19 paragraph (b);

378.20 (2) ensuring the duties of the designated coordinator are fulfilled according to the
378.21 requirements in subdivision 2;

378.22 (3) ensuring the program implements corrective action identified as necessary
378.23 by the program following review of incident and emergency reports according to the
378.24 requirements in section 245D.11, subdivision 2, clause (7). An internal review of
378.25 incident reports of alleged or suspected maltreatment must be conducted according to the
378.26 requirements in section 245A.65, subdivision 1, paragraph (b);

378.27 (4) evaluation of satisfaction of persons served by the program, the person's legal
378.28 representative, if any, and the case manager, with the service delivery and progress
378.29 towards accomplishing outcomes identified in sections 245D.07 and 245D.071, and
378.30 ensuring and protecting each person's rights as identified in section 245D.04;

378.31 (5) ensuring staff competency requirements are met according to the requirements in
378.32 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
378.33 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

378.34 (6) ensuring corrective action is taken when ordered by the commissioner and that
378.35 the terms and condition of the license and any variances are met; and

379.1 (7) evaluating the information identified in clauses (1) to (6) to develop, document,
379.2 and implement ongoing program improvements.

379.3 (b) The designated manager must be competent to perform the duties as required and
379.4 must minimally meet the education and training requirements identified in subdivision
379.5 2, paragraph (b), and have a minimum of three years of supervisory level experience in
379.6 a program providing direct support services to persons with disabilities or persons age
379.7 65 and older.

379.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

379.9 Sec. 32. Minnesota Statutes 2012, section 245D.09, is amended to read:

379.10 **245D.09 STAFFING STANDARDS.**

379.11 Subdivision 1. **Staffing requirements.** The license holder must provide the level of
379.12 direct service support staff sufficient supervision, assistance, and training necessary:

379.13 (1) to ensure the health, safety, and protection of rights of each person; and

379.14 (2) to be able to implement the responsibilities assigned to the license holder in each
379.15 person's coordinated service and support plan or identified in the coordinated service and
379.16 support plan addendum, according to the requirements of this chapter.

379.17 Subd. 2. **Supervision of staff having direct contact.** Except for a license holder
379.18 who is the sole direct service support staff, the license holder must provide adequate
379.19 supervision of staff providing direct service support to ensure the health, safety, and
379.20 protection of rights of each person and implementation of the responsibilities assigned to
379.21 the license holder in each person's ~~service plan~~ coordinated service and support plan or
379.22 coordinated service and support plan addendum.

379.23 Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff is
379.24 providing direct support, or staff who have responsibilities related to supervising or
379.25 managing the provision of direct support service, are competent as demonstrated through
379.26 skills and knowledge training, experience, and education to meet the person's needs
379.27 and additional requirements as written in the coordinated service and support plan or
379.28 coordinated service and support plan addendum, or when otherwise required by the case
379.29 manager or the federal waiver plan. The license holder must verify and maintain evidence
379.30 of staff competency, including documentation of:

379.31 (1) education and experience qualifications relevant to the job responsibilities
379.32 assigned to the staff and the needs of the general population of persons served by the
379.33 program, including a valid degree and transcript, or a current license, registration, or
379.34 certification, when a degree or licensure, registration, or certification is required by this

380.1 chapter or in the coordinated service and support plan or coordinated service and support
380.2 plan addendum;

380.3 (2) ~~completion of required~~ demonstrated competency in the orientation and training
380.4 areas required under this chapter, including and when applicable, completion of continuing
380.5 education required to maintain professional licensure, registration, or certification
380.6 requirements. Competency in these areas is determined by the license holder through
380.7 knowledge testing and observed skill assessment conducted by the trainer or instructor; and

380.8 (3) except for a license holder who is the sole direct service support staff, periodic
380.9 performance evaluations completed by the license holder of the direct service support staff
380.10 person's ability to perform the job functions based on direct observation.

380.11 (b) Staff under 18 years of age may not perform overnight duties or administer
380.12 medication.

380.13 Subd. 4. **Orientation to program requirements.** (a) Except for a license holder
380.14 who does not supervise any direct service support staff, within 90 days of hiring direct
380.15 service staff 60 days of hire, unless stated otherwise, the license holder must provide
380.16 and ensure completion of 30 hours of orientation for direct support staff that combines
380.17 supervised on-the-job training with review of and instruction on in the following areas:

380.18 (1) the job description and how to complete specific job functions, including:

380.19 (i) responding to and reporting incidents as required under section 245D.06,
380.20 subdivision 1; and

380.21 (ii) following safety practices established by the license holder and as required in
380.22 section 245D.06, subdivision 2;

380.23 (2) the license holder's current policies and procedures required under this chapter,
380.24 including their location and access, and staff responsibilities related to implementation
380.25 of those policies and procedures;

380.26 (3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the
380.27 federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff
380.28 responsibilities related to complying with data privacy practices;

380.29 (4) the service recipient rights ~~under section 245D.04,~~ and staff responsibilities
380.30 related to ensuring the exercise and protection of those rights according to the requirements
380.31 in section 245D.04;

380.32 (5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment
380.33 reporting and service planning for children and vulnerable adults, and staff responsibilities
380.34 related to protecting persons from maltreatment and reporting maltreatment. This
380.35 orientation must be provided within 72 hours of first providing direct contact services and
380.36 annually thereafter according to section 245A.65, subdivision 3;

381.1 (6) ~~what constitutes use of restraints, seclusion, and psychotropic medications,~~
381.2 ~~and staff responsibilities related to the prohibitions of their use~~ the principles of
381.3 person-centered service planning and delivery as identified in section 245D.07, subdivision
381.4 1a, and how they apply to direct support service provided by the staff person; and

381.5 (7) other topics as determined necessary in the person's coordinated service and
381.6 support plan by the case manager or other areas identified by the license holder.

381.7 ~~(b) License holders who provide direct service themselves must complete the~~
381.8 ~~orientation required in paragraph (a), clauses (3) to (7).~~

381.9 Subd. 4a. Orientation to individual service recipient needs. ~~(e)~~ (a) Before
381.10 providing having unsupervised direct service ~~to contact with~~ a person served by the
381.11 program, or for whom the staff person has not previously provided direct service support,
381.12 or any time the plans or procedures identified in ~~clauses (1) and (2)~~ paragraphs (b) to
381.13 (f) are revised, the staff person must review and receive instruction on the ~~following~~
381.14 ~~as it relates~~ requirements in paragraphs (b) to (f) as they relate to the staff person's job
381.15 functions for that person.

381.16 (b) Training and competency evaluations must include the following:

381.17 (1) appropriate and safe techniques in personal hygiene and grooming, including
381.18 hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of
381.19 daily living (ADLs) as defined under section 256B.0659, subdivision 1;

381.20 (2) an understanding of what constitutes a healthy diet according to data from the
381.21 Centers for Disease Control and Prevention and the skills necessary to prepare that diet;

381.22 (3) skills necessary to provide appropriate support in instrumental activities of daily
381.23 living (IADLs) as defined under section 256B.0659, subdivision 1; and

381.24 (4) demonstrated competence in providing first aid.

381.25 ~~(+)~~ (c) The staff person must review and receive instruction on the person's
381.26 coordinated service and support plan or coordinated service and support plan addendum as
381.27 it relates to the responsibilities assigned to the license holder, and when applicable, the
381.28 person's individual abuse prevention plan ~~according to section 245A.65,~~ to achieve and
381.29 demonstrate an understanding of the person as a unique individual, and how to implement
381.30 those plans; ~~and.~~

381.31 ~~(2)~~ (d) The staff person must review and receive instruction on medication
381.32 administration procedures established for the person when medication administration is
381.33 assigned to the license holder according to section 245D.05, subdivision 1, paragraph
381.34 (b). Unlicensed staff may administer medications only after successful completion of a
381.35 medication administration training, from a training curriculum developed by a registered
381.36 nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse

382.1 practitioner, physician's assistant, or physician ~~incorporating~~. The training curriculum
382.2 must incorporate an observed skill assessment conducted by the trainer to ensure staff
382.3 demonstrate the ability to safely and correctly follow medication procedures.

382.4 Medication administration must be taught by a registered nurse, clinical nurse
382.5 specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of
382.6 service initiation or any time thereafter, the person has or develops a health care condition
382.7 that affects the service options available to the person because the condition requires:

382.8 (i) specialized or intensive medical or nursing supervision; and

382.9 (ii) nonmedical service providers to adapt their services to accommodate the
382.10 health and safety needs of the person; and

382.11 ~~(iii) necessary training in order to meet the health service needs of the person as~~
382.12 ~~determined by the person's physician.~~

382.13 (e) The staff person must review and receive instruction on the safe and correct
382.14 operation of medical equipment used by the person to sustain life, including but not
382.15 limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided
382.16 by a licensed health care professional or a manufacturer's representative and incorporate
382.17 an observed skill assessment to ensure staff demonstrate the ability to safely and correctly
382.18 operate the equipment according to the treatment orders and the manufacturer's instructions.

382.19 (f) The staff person must review and receive instruction on what constitutes use of
382.20 restraints, time out, and seclusion, including chemical restraint, and staff responsibilities
382.21 related to the prohibitions of their use according to the requirements in section 245D.06,
382.22 subdivision 5, why such procedures are not effective for reducing or eliminating symptoms
382.23 or undesired behavior and why they are not safe, and the safe and correct use of manual
382.24 restraint on an emergency basis according to the requirements in section 245D.061.

382.25 (g) In the event of an emergency service initiation, the license holder must ensure
382.26 the training required in this subdivision occurs within 72 hours of the direct support staff
382.27 person first having unsupervised contact with the person receiving services. The license
382.28 holder must document the reason for the unplanned or emergency service initiation and
382.29 maintain the documentation in the person's service recipient record.

382.30 (h) License holders who provide direct support services themselves must complete
382.31 the orientation required in subdivision 4, clauses (3) to (7).

382.32 Subd. 5. **Annual training.** ~~(a)~~ A license holder must provide annual training
382.33 to direct service support staff on the topics identified in subdivision 4, ~~paragraph (a),~~
382.34 clauses (3) to (6) (7), and subdivision 4a. A license holder must provide a minimum of 24
382.35 hours of annual training to direct service staff with fewer than five years of documented
382.36 experience and 12 hours of annual training to direct service staff with five or more years

383.1 of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a)
383.2 to (h). Training on relevant topics received from sources other than the license holder
383.3 may count toward training requirements.

383.4 ~~(b) A license holder providing behavioral programming, specialist services, personal~~
383.5 ~~support, 24-hour emergency assistance, night supervision, independent living skills,~~
383.6 ~~structured day, prevocational, or supported employment services must provide a minimum~~
383.7 ~~of eight hours of annual training to direct service staff that addresses:~~

383.8 ~~(1) topics related to the general health, safety, and service needs of the population~~
383.9 ~~served by the license holder; and~~

383.10 ~~(2) other areas identified by the license holder or in the person's current service plan.~~

383.11 ~~Training on relevant topics received from sources other than the license holder~~
383.12 ~~may count toward training requirements.~~

383.13 ~~(c) When the license holder is the owner, lessor, or tenant of the service site and~~
383.14 ~~whenever a person receiving services is present at the site, the license holder must have~~
383.15 ~~a staff person available on site who is trained in basic first aid and, when required in a~~
383.16 ~~person's service plan, cardiopulmonary resuscitation.~~

383.17 Subd. 5a. **Alternative sources of training.** Orientation or training received by the
383.18 staff person from sources other than the license holder in the same subjects as identified
383.19 in subdivision 4 may count toward the orientation and annual training requirements if
383.20 received in the 12-month period before the staff person's date of hire. The license holder
383.21 must maintain documentation of the training received from other sources and of each staff
383.22 person's competency in the required area according to the requirements in subdivision 3.

383.23 Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a
383.24 subcontractor or temporary staff to perform services licensed under this chapter on the
383.25 license holder's behalf, the license holder must ensure that the subcontractor or temporary
383.26 staff meets and maintains compliance with all requirements under this chapter that apply
383.27 to the services to be provided, including training, orientation, and supervision necessary
383.28 to fulfill their responsibilities. The license holder must ensure that a background study
383.29 has been completed according to the requirements in sections 245C.03, subdivision 1,
383.30 and 245C.04. Subcontractors and temporary staff hired by the license holder must meet
383.31 the Minnesota licensing requirements applicable to the disciplines in which they are
383.32 providing services. The license holder must maintain documentation that the applicable
383.33 requirements have been met.

383.34 Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide
383.35 direct support services to persons served by the program receive the training, orientation,
383.36 and supervision necessary to fulfill their responsibilities. The license holder must ensure

384.1 that a background study has been completed according to the requirements in sections
384.2 245C.03, subdivision 1, and 245C.04. The license holder must maintain documentation
384.3 that the applicable requirements have been met.

384.4 Subd. 8. **Staff orientation and training plan.** The license holder must develop
384.5 a staff orientation and training plan documenting when and how compliance with
384.6 subdivisions 4, 4a, and 5 will be met.

384.7 **EFFECTIVE DATE.** This section is effective January 1, 2014.

384.8 Sec. 33. **[245D.091] INTERVENTION SERVICES.**

384.9 Subdivision 1. **Licensure requirements.** An individual meeting the staff
384.10 qualification requirements of this section who is an employee of a program licensed
384.11 according to this chapter and providing behavioral support services, specialist services,
384.12 or crisis respite services is not required to hold a separate license under this chapter.
384.13 An individual meeting the staff qualifications of this section who is not providing these
384.14 services as an employee of a program licensed according to this chapter must obtain a
384.15 license according to this chapter.

384.16 Subd. 2. **Behavior professional qualifications.** A behavior professional, as defined
384.17 in the brain injury and community alternatives for disabled individuals waiver plans or
384.18 successor plans, must have competencies in areas related to:

384.19 (1) ethical considerations;

384.20 (2) functional assessment;

384.21 (3) functional analysis;

384.22 (4) measurement of behavior and interpretation of data;

384.23 (5) selecting intervention outcomes and strategies;

384.24 (6) behavior reduction and elimination strategies that promote least restrictive
384.25 approved alternatives;

384.26 (7) data collection;

384.27 (8) staff and caregiver training;

384.28 (9) support plan monitoring;

384.29 (10) co-occurring mental disorders or neuro-cognitive disorder;

384.30 (11) demonstrated expertise with populations being served; and

384.31 (12) must be a:

384.32 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the
384.33 Board of Psychology competencies in the above identified areas;

384.34 (ii) clinical social worker licensed as an independent clinical social worker under
384.35 chapter 148D, or a person with a master's degree in social work from an accredited college

385.1 or university, with at least 4,000 hours of post-master's supervised experience in the
385.2 delivery of clinical services in the areas identified in clauses (1) to (11);

385.3 (iii) physician licensed under chapter 147 and certified by the American Board
385.4 of Psychiatry and Neurology or eligible for board certification in psychiatry with
385.5 competencies in the areas identified in clauses (1) to (11);

385.6 (iv) licensed professional clinical counselor licensed under sections 148B.29 to
385.7 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery
385.8 of clinical services who has demonstrated competencies in the areas identified in clauses
385.9 (1) to (11);

385.10 (v) person with a master's degree from an accredited college or university in one
385.11 of the behavioral sciences or related fields, with at least 4,000 hours of post-master's
385.12 supervised experience in the delivery of clinical services with demonstrated competencies
385.13 in the areas identified in clauses (1) to (11); or

385.14 (vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is
385.15 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
385.16 mental health nursing by a national nurse certification organization, or who has a master's
385.17 degree in nursing or one of the behavioral sciences or related fields from an accredited
385.18 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
385.19 experience in the delivery of clinical services.

385.20 Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst, as defined in
385.21 the brain injury and community alternatives for disabled individuals waiver plans or
385.22 successor plans, must:

385.23 (1) have obtained a baccalaureate degree, master's degree, or PhD in a social services
385.24 discipline; or

385.25 (2) meet the qualifications of a mental health practitioner as defined in section
385.26 245.462, subdivision 17.

385.27 (b) In addition, a behavior analyst must:

385.28 (1) have four years of supervised experience working with individuals who exhibit
385.29 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder;

385.30 (2) have received ten hours of instruction in functional assessment and functional
385.31 analysis;

385.32 (3) have received 20 hours of instruction in the understanding of the function of
385.33 behavior;

385.34 (4) have received ten hours of instruction on design of positive practices behavior
385.35 support strategies;

386.1 (5) have received 20 hours of instruction on the use of behavior reduction approved
386.2 strategies used only in combination with behavior positive practices strategies;

386.3 (6) be determined by a behavior professional to have the training and prerequisite
386.4 skills required to provide positive practice strategies as well as behavior reduction
386.5 approved and permitted intervention to the person who receives behavioral support; and

386.6 (7) be under the direct supervision of a behavior professional.

386.7 Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist, as defined
386.8 in the brain injury and community alternatives for disabled individuals waiver plans or
386.9 successor plans, must meet the following qualifications:

386.10 (1) have an associate's degree in a social services discipline; or

386.11 (2) have two years of supervised experience working with individuals who exhibit
386.12 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder.

386.13 (b) In addition, a behavior specialist must:

386.14 (1) have received a minimum of four hours of training in functional assessment;

386.15 (2) have received 20 hours of instruction in the understanding of the function of
386.16 behavior;

386.17 (3) have received ten hours of instruction on design of positive practices behavioral
386.18 support strategies;

386.19 (4) be determined by a behavior professional to have the training and prerequisite
386.20 skills required to provide positive practices strategies as well as behavior reduction
386.21 approved intervention to the person who receives behavioral support; and

386.22 (5) be under the direct supervision of a behavior professional.

386.23 Subd. 5. **Specialist services qualifications.** An individual providing specialist
386.24 services, as defined in the developmental disabilities waiver plan or successor plan, must
386.25 have:

386.26 (1) the specific experience and skills required of the specialist to meet the needs of
386.27 the person identified by the person's service planning team; and

386.28 (2) the qualifications of the specialist identified in the person's coordinated service
386.29 and support plan.

386.30 **EFFECTIVE DATE.** This section is effective January 1, 2014.

386.31 **Sec. 34. [245D.095] RECORD REQUIREMENTS.**

386.32 Subdivision 1. **Record-keeping systems.** The license holder must ensure that the
386.33 content and format of service recipient, personnel, and program records are uniform and
386.34 legible according to the requirements of this chapter.

387.1 Subd. 2. Admission and discharge register. The license holder must keep a written
387.2 or electronic register, listing in chronological order the dates and names of all persons
387.3 served by the program who have been admitted, discharged, or transferred, including
387.4 service terminations initiated by the license holder and deaths.

387.5 Subd. 3. Service recipient record. (a) The license holder must maintain a record of
387.6 current services provided to each person on the premises where the services are provided
387.7 or coordinated. When the services are provided in a licensed facility, the records must
387.8 be maintained at the facility, otherwise the records must be maintained at the license
387.9 holder's program office. The license holder must protect service recipient records against
387.10 loss, tampering, or unauthorized disclosure according to the requirements in sections
387.11 13.01 to 13.10 and 13.46.

387.12 (b) The license holder must maintain the following information for each person:

387.13 (1) an admission form signed by the person or the person's legal representative
387.14 that includes:

387.15 (i) identifying information, including the person's name, date of birth, address,
387.16 and telephone number; and

387.17 (ii) the name, address, and telephone number of the person's legal representative, if
387.18 any, and a primary emergency contact, the case manager, and family members or others as
387.19 identified by the person or case manager;

387.20 (2) service information, including service initiation information, verification of the
387.21 person's eligibility for services, documentation verifying that services have been provided
387.22 as identified in the coordinated service and support plan or coordinated service and support
387.23 plan addendum according to paragraph (a), and date of admission or readmission;

387.24 (3) health information, including medical history, special dietary needs, and
387.25 allergies, and when the license holder is assigned responsibility for meeting the person's
387.26 health service needs according to section 245D.05:

387.27 (i) current orders for medication, treatments, or medical equipment and a signed
387.28 authorization from the person or the person's legal representative to administer or assist in
387.29 administering the medication or treatments, if applicable;

387.30 (ii) a signed statement authorizing the license holder to act in a medical emergency
387.31 when the person's legal representative, if any, cannot be reached or is delayed in arriving;

387.32 (iii) medication administration procedures;

387.33 (iv) a medication administration record documenting the implementation of the
387.34 medication administration procedures, and the medication administration record reviews,
387.35 including any agreements for administration of injectable medications by the license
387.36 holder according to the requirements in section 245D.05; and

- 388.1 (v) a medical appointment schedule when the license holder is assigned
388.2 responsibility for assisting with medical appointments;
- 388.3 (4) the person's current coordinated service and support plan or that portion of the
388.4 plan assigned to the license holder;
- 388.5 (5) copies of the individual abuse prevention plan and assessments as required under
388.6 section 245D.071, subdivisions 2 and 3;
- 388.7 (6) a record of other service providers serving the person when the person's
388.8 coordinated service and support plan or coordinated service and support plan addendum
388.9 identifies the need for coordination between the service providers, that includes a contact
388.10 person and telephone numbers, services being provided, and names of staff responsible for
388.11 coordination;
- 388.12 (7) documentation of orientation to service recipient rights according to section
388.13 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to
388.14 section 245A.65, subdivision 1, paragraph (c);
- 388.15 (8) copies of authorizations to handle a person's funds, according to section 245D.06,
388.16 subdivision 4, paragraph (a);
- 388.17 (9) documentation of complaints received and grievance resolution;
- 388.18 (10) incident reports involving the person, required under section 245D.06,
388.19 subdivision 1;
- 388.20 (11) copies of written reports regarding the person's status when requested according
388.21 to section 245D.07, subdivision 3, progress review reports as required under section
388.22 245D.071, subdivision 5, progress or daily log notes that are recorded by the program,
388.23 and reports received from other agencies involved in providing services or care to the
388.24 person; and
- 388.25 (12) discharge summary, including service termination notice and related
388.26 documentation, when applicable.
- 388.27 Subd. 4. **Access to service recipient records.** The license holder must ensure that
388.28 the following people have access to the information in subdivision 1 in accordance with
388.29 applicable state and federal laws, regulations, or rules:
- 388.30 (1) the person, the person's legal representative, and anyone properly authorized
388.31 by the person;
- 388.32 (2) the person's case manager;
- 388.33 (3) staff providing services to the person unless the information is not relevant to
388.34 carrying out the coordinated service and support plan or coordinated service and support
388.35 plan addendum; and

389.1 (4) the county child or adult foster care licenser, when services are also licensed as
389.2 child or adult foster care.

389.3 Subd. 5. **Personnel records.** (a) The license holder must maintain a personnel
389.4 record of each employee to document and verify staff qualifications, orientation, and
389.5 training. The personnel record must include:

389.6 (1) the employee's date of hire, completed application, an acknowledgement signed
389.7 by the employee that job duties were reviewed with the employee and the employee
389.8 understands those duties, and documentation that the employee meets the position
389.9 requirements as determined by the license holder;

389.10 (2) documentation of staff qualifications, orientation, training, and performance
389.11 evaluations as required under section 245D.09, subdivisions 3 to 5, including the date
389.12 the training was completed, the number of hours per subject area, and the name of the
389.13 trainer or instructor; and

389.14 (3) a completed background study as required under chapter 245C.

389.15 (b) For employees hired after January 1, 2014, the license holder must maintain
389.16 documentation in the personnel record or elsewhere, sufficient to determine the date of the
389.17 employee's first supervised direct contact with a person served by the program, and the
389.18 date of first unsupervised direct contact with a person served by the program.

389.19 **EFFECTIVE DATE.** This section is effective January 1, 2014.

389.20 Sec. 35. Minnesota Statutes 2012, section 245D.10, is amended to read:

389.21 **245D.10 POLICIES AND PROCEDURES.**

389.22 Subdivision 1. **Policy and procedure requirements.** The A license holder
389.23 providing either basic or intensive supports and services must establish, enforce, and
389.24 maintain policies and procedures as required in this chapter, chapter 245A, and other
389.25 applicable state and federal laws and regulations governing the provision of home and
389.26 community-based services licensed according to this chapter.

389.27 Subd. 2. **Grievances.** The license holder must establish policies and procedures
389.28 that ~~provide~~ promote service recipient rights by providing a simple complaint process for
389.29 persons served by the program and their authorized representatives to bring a grievance that:

389.30 (1) provides staff assistance with the complaint process when requested, and the
389.31 addresses and telephone numbers of outside agencies to assist the person;

389.32 (2) allows the person to bring the complaint to the highest level of authority in the
389.33 program if the grievance cannot be resolved by other staff members, and that provides
389.34 the name, address, and telephone number of that person;

390.1 (3) requires the license holder to promptly respond to all complaints affecting a
390.2 person's health and safety. For all other complaints, the license holder must provide an
390.3 initial response within 14 calendar days of receipt of the complaint. All complaints must
390.4 be resolved within 30 calendar days of receipt or the license holder must document the
390.5 reason for the delay and a plan for resolution;

390.6 (4) requires a complaint review that includes an evaluation of whether:

390.7 (i) related policies and procedures were followed and adequate;

390.8 (ii) there is a need for additional staff training;

390.9 (iii) the complaint is similar to past complaints with the persons, staff, or services
390.10 involved; and

390.11 (iv) there is a need for corrective action by the license holder to protect the health
390.12 and safety of persons receiving services;

390.13 (5) based on the review in clause (4), requires the license holder to develop,
390.14 document, and implement a corrective action plan designed to correct current lapses and
390.15 prevent future lapses in performance by staff or the license holder, if any;

390.16 (6) provides a written summary of the complaint and a notice of the complaint
390.17 resolution to the person and case manager that:

390.18 (i) identifies the nature of the complaint and the date it was received;

390.19 (ii) includes the results of the complaint review;

390.20 (iii) identifies the complaint resolution, including any corrective action; and

390.21 (7) requires that the complaint summary and resolution notice be maintained in the
390.22 service recipient record.

390.23 Subd. 3. **Service suspension and service termination.** (a) The license holder must
390.24 establish policies and procedures for temporary service suspension and service termination
390.25 that promote continuity of care and service coordination with the person and the case
390.26 manager and with other licensed caregivers, if any, who also provide support to the person.

390.27 (b) The policy must include the following requirements:

390.28 (1) the license holder must notify the person or the person's legal representative and
390.29 case manager in writing of the intended termination or temporary service suspension, and
390.30 the person's right to seek a temporary order staying the termination of service according to
390.31 the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

390.32 (2) notice of the proposed termination of services, including those situations
390.33 that began with a temporary service suspension, must be given at least 60 days before
390.34 the proposed termination is to become effective when a license holder is providing
390.35 ~~independent living skills training, structured day, prevocational or supported employment~~
390.36 ~~services to the person~~ intensive supports and services identified in section 245D.03,

391.1 subdivision 1, paragraph (c), and 30 days prior to termination for all other services
391.2 licensed under this chapter;

391.3 (3) the license holder must provide information requested by the person or case
391.4 manager when services are temporarily suspended or upon notice of termination;

391.5 (4) prior to giving notice of service termination or temporary service suspension,
391.6 the license holder must document actions taken to minimize or eliminate the need for
391.7 service suspension or termination;

391.8 (5) during the temporary service suspension or service termination notice period,
391.9 the license holder will work with the appropriate county agency to develop reasonable
391.10 alternatives to protect the person and others;

391.11 (6) the license holder must maintain information about the service suspension or
391.12 termination, including the written termination notice, in the service recipient record; and

391.13 (7) the license holder must restrict temporary service suspension to situations in
391.14 which the person's ~~behavior causes immediate and serious danger to the health and safety~~
391.15 ~~of the person or others~~ conduct poses an imminent risk of physical harm to self or others
391.16 and less restrictive or positive support strategies would not achieve safety.

391.17 Subd. 4. **Availability of current written policies and procedures.** (a) The license
391.18 holder must review and update, as needed, the written policies and procedures required
391.19 under this chapter.

391.20 (b)(1) The license holder must inform the person and case manager of the policies
391.21 and procedures affecting a person's rights under section 245D.04, and provide copies of
391.22 those policies and procedures, within five working days of service initiation.

391.23 (2) If a license holder only provides basic services and supports, this includes the:

391.24 (i) grievance policy and procedure required under subdivision 2; and

391.25 (ii) service suspension and termination policy and procedure required under
391.26 subdivision 3.

391.27 (3) For all other license holders this includes the:

391.28 (i) policies and procedures in clause (2);

391.29 (ii) emergency use of manual restraints policy and procedure required under section
391.30 245D.061, subdivision 10; and

391.31 (iii) data privacy requirements under section 245D.11, subdivision 3.

391.32 (c) The license holder must provide a written notice to all persons or their legal
391.33 representatives and case managers at least 30 days before implementing any revised
391.34 policies and procedures procedural revisions to policies affecting a person's service-related
391.35 or protection-related rights under section 245D.04 and maltreatment reporting policies and
391.36 procedures. The notice must explain the revision that was made and include a copy of the

392.1 revised policy and procedure. The license holder must document the ~~reason~~ reasonable
392.2 cause for not providing the notice at least 30 days before implementing the revisions.

392.3 (d) Before implementing revisions to required policies and procedures, the license
392.4 holder must inform all employees of the revisions and provide training on implementation
392.5 of the revised policies and procedures.

392.6 (e) The license holder must annually notify all persons, or their legal representatives,
392.7 and case managers of any procedural revisions to policies required under this chapter,
392.8 other than those in paragraph (c). Upon request, the license holder must provide the
392.9 person, or the person's legal representative, and case manager with copies of the revised
392.10 policies and procedures.

392.11 **EFFECTIVE DATE.** This section is effective January 1, 2014.

392.12 Sec. 36. **[245D.11] POLICIES AND PROCEDURES; INTENSIVE SUPPORT**
392.13 **SERVICES.**

392.14 Subdivision 1. Policy and procedure requirements. A license holder providing
392.15 intensive support services as identified in section 245D.03, subdivision 1, paragraph (c),
392.16 must establish, enforce, and maintain policies and procedures as required in this section.

392.17 Subd. 2. Health and safety. The license holder must establish policies and
392.18 procedures that promote health and safety by ensuring:

392.19 (1) use of universal precautions and sanitary practices in compliance with section
392.20 245D.06, subdivision 2, clause (5);

392.21 (2) if the license holder operates a residential program, health service coordination
392.22 and care according to the requirements in section 245D.05, subdivision 1;

392.23 (3) safe medication assistance and administration according to the requirements
392.24 in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
392.25 consultation with a registered nurse, nurse practitioner, physician's assistant, or medical
392.26 doctor and require completion of medication administration training according to the
392.27 requirements in section 245D.09, subdivision 4a, paragraph (d). Medication assistance
392.28 and administration includes, but is not limited to:

392.29 (i) providing medication-related services for a person;

392.30 (ii) medication setup;

392.31 (iii) medication administration;

392.32 (iv) medication storage and security;

392.33 (v) medication documentation and charting;

392.34 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
392.35 handling and administration;

- 393.1 (vii) coordination of medication refills;
393.2 (viii) handling changes to prescriptions and implementation of those changes;
393.3 (ix) communicating with the pharmacy; and
393.4 (x) coordination and communication with prescriber;
393.5 (4) safe transportation, when the license holder is responsible for transportation of
393.6 persons, with provisions for handling emergency situations according to the requirements
393.7 in section 245D.06, subdivision 2, clauses (2) to (4);
393.8 (5) a plan for ensuring the safety of persons served by the program in emergencies as
393.9 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
393.10 to the license holder. A license holder with a community residential setting or a day service
393.11 facility license must ensure the policy and procedures comply with the requirements in
393.12 section 245D.22, subdivision 4;
393.13 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision
393.14 11; and reporting all incidents required to be reported according to section 245D.06,
393.15 subdivision 1. The plan must:
393.16 (i) provide the contact information of a source of emergency medical care and
393.17 transportation; and
393.18 (ii) require staff to first call 911 when the staff believes a medical emergency may be
393.19 life threatening, or to call the mental health crisis intervention team when the person is
393.20 experiencing a mental health crisis; and
393.21 (7) a procedure for the review of incidents and emergencies to identify trends or
393.22 patterns, and corrective action if needed. The license holder must establish and maintain
393.23 a record-keeping system for the incident and emergency reports. Each incident and
393.24 emergency report file must contain a written summary of the incident. The license holder
393.25 must conduct a review of incident reports for identification of incident patterns, and
393.26 implementation of corrective action as necessary to reduce occurrences. Each incident
393.27 report must include:
393.28 (i) the name of the person or persons involved in the incident. It is not necessary
393.29 to identify all persons affected by or involved in an emergency unless the emergency
393.30 resulted in an incident;
393.31 (ii) the date, time, and location of the incident or emergency;
393.32 (iii) a description of the incident or emergency;
393.33 (iv) a description of the response to the incident or emergency and whether a person's
393.34 coordinated service and support plan addendum or program policies and procedures were
393.35 implemented as applicable;

394.1 (v) the name of the staff person or persons who responded to the incident or
394.2 emergency; and

394.3 (vi) the determination of whether corrective action is necessary based on the results
394.4 of the review.

394.5 Subd. 3. **Data privacy.** The license holder must establish policies and procedures that
394.6 promote service recipient rights by ensuring data privacy according to the requirements in:

394.7 (1) the Minnesota Government Data Practices Act, section 13.46, and all other
394.8 applicable Minnesota laws and rules in handling all data related to the services provided;
394.9 and

394.10 (2) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the
394.11 extent that the license holder performs a function or activity involving the use of protected
394.12 health information as defined under Code of Federal Regulations, title 45, section 164.501,
394.13 including, but not limited to, providing health care services; health care claims processing
394.14 or administration; data analysis, processing, or administration; utilization review; quality
394.15 assurance; billing; benefit management; practice management; repricing; or as otherwise
394.16 provided by Code of Federal Regulations, title 45, section 160.103. The license holder
394.17 must comply with the Health Insurance Portability and Accountability Act of 1996 and
394.18 its implementing regulations, Code of Federal Regulations, title 45, parts 160 to 164,
394.19 and all applicable requirements.

394.20 Subd. 4. **Admission criteria.** The license holder must establish policies and
394.21 procedures that promote continuity of care by ensuring that admission or service initiation
394.22 criteria:

394.23 (1) is consistent with the license holder's registration information identified in the
394.24 requirements in section 245D.031, subdivision 2, and with the service-related rights
394.25 identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

394.26 (2) identifies the criteria to be applied in determining whether the license holder
394.27 can develop services to meet the needs specified in the person's coordinated service and
394.28 support plan;

394.29 (3) requires a license holder providing services in a health care facility to comply
394.30 with the requirements in section 243.166, subdivision 4b, to provide notification to
394.31 residents when a registered predatory offender is admitted into the program or to a
394.32 potential admission when the facility was already serving a registered predatory offender.
394.33 For purposes of this clause, "health care facility" means a facility licensed by the
394.34 commissioner as a residential facility under chapter 245A to provide adult foster care or
394.35 residential services to persons with disabilities; and

395.1 (4) requires that when a person or the person's legal representative requests services
395.2 from the license holder, a refusal to admit the person must be based on an evaluation of
395.3 the person's assessed needs and the license holder's lack of capacity to meet the needs of
395.4 the person. The license holder must not refuse to admit a person based solely on the
395.5 type of residential services the person is receiving, or solely on the person's severity of
395.6 disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of
395.7 communication skills, physical disabilities, toilet habits, behavioral disorders, or past
395.8 failure to make progress. Documentation of the basis for refusal must be provided to the
395.9 person or the person's legal representative and case manager upon request.

395.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

395.11 Sec. 37. **[245D.21] FACILITY LICENSURE REQUIREMENTS AND**
395.12 **APPLICATION PROCESS.**

395.13 Subdivision 1. **Community residential settings and day service facilities.** For
395.14 purposes of this section, "facility" means both a community residential setting and day
395.15 service facility and the physical plant.

395.16 Subd. 2. **Inspections and code compliance.** (a) Physical plants must comply with
395.17 applicable state and local fire, health, building, and zoning codes.

395.18 (b)(1) The facility must be inspected by a fire marshal or their delegate within
395.19 12 months before initial licensure to verify that it meets the applicable occupancy
395.20 requirements as defined in the State Fire Code and that the facility complies with the fire
395.21 safety standards for that occupancy code contained in the State Fire Code.

395.22 (2) The fire marshal inspection of a community residential setting must verify the
395.23 residence is a dwelling unit within a residential occupancy as defined in section 9.117 of
395.24 the State Fire Code. A home safety checklist, approved by the commissioner, must be
395.25 completed for a community residential setting by the license holder and the commissioner
395.26 before the satellite license is reissued.

395.27 (3) The facility shall be inspected according to the facility capacity specified on the
395.28 initial application form.

395.29 (4) If the commissioner has reasonable cause to believe that a potentially hazardous
395.30 condition may be present or the licensed capacity is increased, the commissioner shall
395.31 request a subsequent inspection and written report by a fire marshal to verify the absence
395.32 of hazard.

395.33 (5) Any condition cited by a fire marshal, building official, or health authority as
395.34 hazardous or creating an immediate danger of fire or threat to health and safety must be

396.1 corrected before a license is issued by the department, and for community residential
396.2 settings, before a license is reissued.

396.3 (c) The facility must maintain in a permanent file the reports of health, fire, and
396.4 other safety inspections.

396.5 (d) The facility's plumbing, ventilation, heating, cooling, lighting, and other
396.6 fixtures and equipment, including elevators or food service, if provided, must conform to
396.7 applicable health, sanitation, and safety codes and regulations.

396.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

396.9 Sec. 38. **[245D.22] FACILITY SANITATION AND HEALTH.**

396.10 Subdivision 1. **General maintenance.** The license holder must maintain the interior
396.11 and exterior of buildings, structures, or enclosures used by the facility, including walls,
396.12 floors, ceilings, registers, fixtures, equipment, and furnishings in good repair and in a
396.13 sanitary and safe condition. The facility must be clean and free from accumulations of
396.14 dirt, grease, garbage, peeling paint, mold, vermin, and insects. The license holder must
396.15 correct building and equipment deterioration, safety hazards, and unsanitary conditions.

396.16 Subd. 2. **Hazards and toxic substances.** The license holder must ensure that
396.17 service sites owned or leased by the license holder are free from hazards that would
396.18 threaten the health or safety of a person receiving services by ensuring the requirements
396.19 in paragraphs (a) to (g) are met.

396.20 (a) Chemicals, detergents, and other hazardous or toxic substances must not be
396.21 stored with food products or in any way that poses a hazard to persons receiving services.

396.22 (b) The license holder must install handrails and nonslip surfaces on interior and
396.23 exterior runways, stairways, and ramps according to the applicable building code.

396.24 (c) If there are elevators in the facility, the license holder must have elevators
396.25 inspected each year. The date of the inspection, any repairs needed, and the date the
396.26 necessary repairs were made must be documented.

396.27 (d) The license holder must keep stairways, ramps, and corridors free of obstructions.

396.28 (e) Outside property must be free from debris and safety hazards. Exterior stairs and
396.29 walkways must be kept free of ice and snow.

396.30 (f) Heating, ventilation, air conditioning units, and other hot surfaces and moving
396.31 parts of machinery must be shielded or enclosed.

396.32 (g) Use of dangerous items or equipment by persons served by the program must be
396.33 allowed in accordance with the person's coordinated service and support plan addendum
396.34 or the program abuse prevention plan, if not addressed in the coordinated service and
396.35 support plan addendum.

397.1 Subd. 3. **Storage and disposal of medication.** Schedule II controlled substances in
397.2 the facility that are named in section 152.02, subdivision 3, must be stored in a locked
397.3 storage area permitting access only by persons and staff authorized to administer the
397.4 medication. This must be incorporated into the license holder's medication administration
397.5 policy and procedures required under section 245D.11, subdivision 2, clause (3).
397.6 Medications must be disposed of according to the Environmental Protection Agency
397.7 recommendations.

397.8 Subd. 4. **First aid must be available on site.** (a) A staff person trained in first
397.9 aid must be available on site and, when required in a person's coordinated service and
397.10 support plan or coordinated service and support plan addendum, be able to provide
397.11 cardiopulmonary resuscitation, whenever persons are present and staff are required to be
397.12 at the site to provide direct service. The CPR training must include in-person instruction,
397.13 hands-on practice, and an observed skills assessment under the direct supervision of a
397.14 CPR instructor.

397.15 (b) A facility must have first aid kits readily available for use by, and that meet
397.16 the needs of, persons receiving services and staff. At a minimum, the first aid kit must
397.17 be equipped with accessible first aid supplies including bandages, sterile compresses,
397.18 scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap,
397.19 adhesive tape, and first aid manual.

397.20 Subd. 5. **Emergencies.** (a) The license holder must have a written plan for
397.21 responding to emergencies as defined in section 245D.02, subdivision 8, to ensure the
397.22 safety of persons served in the facility. The plan must include:

397.23 (1) procedures for emergency evacuation and emergency sheltering, including:

397.24 (i) how to report a fire or other emergency;

397.25 (ii) procedures to notify, relocate, and evacuate occupants, including use of adaptive
397.26 procedures or equipment to assist with the safe evacuation of persons with physical or
397.27 sensory disabilities; and

397.28 (iii) instructions on closing off the fire area, using fire extinguishers, and activating
397.29 and responding to alarm systems;

397.30 (2) a floor plan that identifies:

397.31 (i) the location of fire extinguishers;

397.32 (ii) the location of audible or visual alarm systems, including but not limited to
397.33 manual fire alarm boxes, smoke detectors, fire alarm enunciators and controls, and
397.34 sprinkler systems;

397.35 (iii) the location of exits, primary and secondary evacuation routes, and accessible
397.36 egress routes, if any; and

- 398.1 (iv) the location of emergency shelter within the facility;
398.2 (3) a site plan that identifies:
398.3 (i) designated assembly points outside the facility;
398.4 (ii) the locations of fire hydrants; and
398.5 (iii) the routes of fire department access;
398.6 (4) the responsibilities each staff person must assume in case of emergency;
398.7 (5) procedures for conducting quarterly drills each year and recording the date of
398.8 each drill in the file of emergency plans;
398.9 (6) procedures for relocation or service suspension when services are interrupted
398.10 for more than 24 hours;
398.11 (7) for a community residential setting with three or more dwelling units, a floor
398.12 plan that identifies the location of enclosed exit stairs; and
398.13 (8) an emergency escape plan for each resident.
398.14 (b) The license holder must:
398.15 (1) maintain a log of quarterly fire drills on file in the facility;
398.16 (2) provide an emergency response plan that is readily available to staff and persons
398.17 receiving services;
398.18 (3) inform each person of a designated area within the facility where the person
398.19 should go for emergency shelter during severe weather and the designated assembly points
398.20 outside the facility; and
398.21 (4) maintain emergency contact information for persons served at the facility that
398.22 can be readily accessed in an emergency.
398.23 Subd. 6. **Emergency equipment.** The facility must have a flashlight and a portable
398.24 radio or television set that do not require electricity and can be used if a power failure
398.25 occurs.
398.26 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin operated
398.27 telephone that is readily accessible. A list of emergency numbers must be posted in a
398.28 prominent location. When an area has a 911 number or a mental health crisis intervention
398.29 team number, both numbers must be posted and the emergency number listed must be
398.30 911. In areas of the state without a 911 number, the numbers listed must be those of the
398.31 local fire department, police department, emergency transportation, and poison control
398.32 center. The names and telephone numbers of each person's representative, physician, and
398.33 dentist must be readily available.
398.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

399.1 Sec. 39. **[245D.23] COMMUNITY RESIDENTIAL SETTINGS; SATELLITE**
399.2 **LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

399.3 Subdivision 1. **Separate satellite license required for separate sites.** (a) A license
399.4 holder providing residential support services must obtain a separate satellite license for
399.5 each community residential setting located at separate addresses when the community
399.6 residential settings are to be operated by the same license holder. For purposes of this
399.7 chapter, a community residential setting is a satellite of the home and community-based
399.8 services license.

399.9 (b) Community residential settings are permitted single-family use homes. After a
399.10 license has been issued, the commissioner shall notify the local municipality where the
399.11 residence is located of the approved license.

399.12 Subd. 2. **Notification to local agency.** The license holder must notify the local
399.13 agency within 24 hours of the onset of changes in a residence resulting from construction,
399.14 remodeling, or damages requiring repairs that require a building permit or may affect a
399.15 licensing requirement in this chapter.

399.16 Subd. 3. **Alternate overnight supervision.** A license holder granted an alternate
399.17 overnight supervision technology adult foster care license according to section 245A.11,
399.18 subdivision 7a, that converts to a community residential setting satellite license according
399.19 to this chapter, must retain that designation.

399.20 **EFFECTIVE DATE.** This section is effective January 1, 2014.

399.21 Sec. 40. **[245D.24] COMMUNITY RESIDENTIAL SETTINGS; PHYSICAL**
399.22 **PLANT AND ENVIRONMENT.**

399.23 Subdivision 1. **Occupancy.** The residence must meet the definition of a dwelling
399.24 unit in a residential occupancy.

399.25 Subd. 2. **Common area requirements.** The living area must be provided with an
399.26 adequate number of furnishings for the usual functions of daily living and social activities.
399.27 The dining area must be furnished to accommodate meals shared by all persons living in
399.28 the residence. These furnishings must be in good repair and functional to meet the daily
399.29 needs of the persons living in the residence.

399.30 Subd. 3. **Bedrooms.** (a) People receiving services must mutually consent, in
399.31 writing, to sharing a bedroom with one another. No more than two people receiving
399.32 services may share one bedroom.

399.33 (b) A single occupancy bedroom must have at least 80 square feet of floor space with
399.34 a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
399.35 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and

400.1 other habitable rooms by floor to ceiling walls containing no openings except doorways
400.2 and must not serve as a corridor to another room used in daily living.

400.3 (c) A person's personal possessions and items for the person's own use are the only
400.4 items permitted to be stored in a person's bedroom.

400.5 (d) Unless otherwise documented through assessment as a safety concern for the
400.6 person, each person must be provided with the following furnishings:

400.7 (1) a separate bed of proper size and height for the convenience and comfort of the
400.8 person, with a clean mattress in good repair;

400.9 (2) clean bedding appropriate for the season for each person;

400.10 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
400.11 possessions and clothing; and

400.12 (4) a mirror for grooming.

400.13 (e) When possible, a person must be allowed to have items of furniture that the
400.14 person personally owns in the bedroom, unless doing so would interfere with safety
400.15 precautions, violate a building or fire code, or interfere with another person's use of the
400.16 bedroom. A person may choose not to have a cabinet, dresser, shelves, or a mirror in the
400.17 bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may
400.18 choose to use a mattress other than an innerspring mattress and may choose not to have
400.19 the mattress on a mattress frame or support. If a person chooses not to have a piece of
400.20 required furniture, the license holder must document this choice and is not required to
400.21 provide the item. If a person chooses to use a mattress other than an innerspring mattress
400.22 or chooses not to have a mattress frame or support, the license holder must document this
400.23 choice and allow the alternative desired by the person.

400.24 (f) A person must be allowed to bring personal possessions into the bedroom
400.25 and other designated storage space, if such space is available, in the residence. The
400.26 person must be allowed to accumulate possessions to the extent the residence is able to
400.27 accommodate them, unless doing so is contraindicated for the person's physical or mental
400.28 health, would interfere with safety precautions or another person's use of the bedroom, or
400.29 would violate a building or fire code. The license holder must allow for locked storage
400.30 of personal items. Any restriction on the possession or locked storage of personal items,
400.31 including requiring a person to use a lock provided by the license holder, must comply
400.32 with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if
400.33 and when the license holder opens the lock.

400.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

401.1 Sec. 41. **[245D.25] COMMUNITY RESIDENTIAL SETTINGS; FOOD AND**
401.2 **WATER.**

401.3 Subdivision 1. **Water.** Potable water from privately owned wells must be tested
401.4 annually by a Department of Health-certified laboratory for coliform bacteria and nitrate
401.5 nitrogens to verify safety. The health authority may require retesting and corrective
401.6 measures if results exceed state water standards in Minnesota Rules, chapter 4720, or in
401.7 the event of flooding or an incident which may put the well at risk of contamination. To
401.8 prevent scalding, the water temperature of faucets must not exceed 120 degrees Fahrenheit.

401.9 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as
401.10 prescribed by the person's physician or dietitian. Three nutritionally balanced meals a day
401.11 must be served or made available to persons, and nutritious snacks must be available
401.12 between meals.

401.13 Subd. 3. **Food safety.** Food must be obtained, handled, and properly stored to
401.14 prevent contamination, spoilage, or a threat to the health of a person.

401.15 **EFFECTIVE DATE.** This section is effective January 1, 2014.

401.16 Sec. 42. **[245D.26] COMMUNITY RESIDENTIAL SETTINGS; SANITATION**
401.17 **AND HEALTH.**

401.18 Subdivision 1. **Goods provided by the license holder.** Individual clean bed linens
401.19 appropriate for the season and the person's comfort, including towels and wash cloths,
401.20 must be available for each person. Usual or customary goods for the operation of a
401.21 residence which are communally used by all persons receiving services living in the
401.22 residence must be provided by the license holder, including household items for meal
401.23 preparation, cleaning supplies to maintain the cleanliness of the residence, window
401.24 coverings on windows for privacy, toilet paper, and hand soap.

401.25 Subd. 2. **Personal items.** Personal health and hygiene items must be stored in a
401.26 safe and sanitary manner.

401.27 Subd. 3. **Pets and service animals.** Pets and service animals housed within
401.28 the residence must be immunized and maintained in good health as required by local
401.29 ordinances and state law. The license holder must ensure that the person and the person's
401.30 representative are notified before admission of the presence of pets in the residence.

401.31 Subd. 4. **Smoking in the residence.** License holders must comply with the
401.32 requirements of the Minnesota Clean Indoor Air Act, sections 144.411 to 144.417, when
401.33 smoking is permitted in the residence.

401.34 Subd. 5. **Weapons.** Weapons and ammunition must be stored separately in locked
401.35 areas that are inaccessible to a person receiving services. For purposes of this subdivision,

402.1 "weapons" means firearms and other instruments or devices designed for and capable of
402.2 producing bodily harm.

402.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

402.4 Sec. 43. **[245D.27] DAY SERVICES FACILITIES; SATELLITE LICENSURE**
402.5 **REQUIREMENTS AND APPLICATION PROCESS.**

402.6 Except for day service facilities on the same or adjoining lot, the license holder
402.7 providing day services must apply for a separate license for each facility-based service
402.8 site when the license holder is the owner, lessor, or tenant of the service site at which
402.9 persons receive day services and the license holder's employees who provide day services
402.10 are present for a cumulative total of more than 30 days within any 12-month period. For
402.11 purposes of this chapter, a day services facility license is a satellite license of the day
402.12 services program. A day services program may operate multiple licensed day service
402.13 facilities in one or more counties in the state. For the purposes of this section, "adjoining
402.14 lot" means day services facilities that are next door to or across the street from one another.

402.15 **EFFECTIVE DATE.** This section is effective January 1, 2014.

402.16 Sec. 44. **[245D.28] DAY SERVICES FACILITIES; PHYSICAL PLANT AND**
402.17 **SPACE REQUIREMENTS.**

402.18 Subdivision 1. **Facility capacity and useable space requirements.** (a) The facility
402.19 capacity of each day service facility must be determined by the amount of primary space
402.20 available, the scheduling of activities at other service sites, and the space requirements of
402.21 all persons receiving services at the facility, not just the licensed services. The facility
402.22 capacity must specify the maximum number of persons that may receive services on
402.23 site at any one time.

402.24 (b) When a facility is located in a multifunctional organization, the facility may
402.25 share common space with the multifunctional organization if the required available
402.26 primary space for use by persons receiving day services is maintained while the facility is
402.27 operating. The license holder must comply at all times with all applicable fire and safety
402.28 codes under section 245A.04, subdivision 2a, and adequate supervision requirements
402.29 under section 245D.31 for all persons receiving day services.

402.30 (c) A day services facility must have a minimum of 40 square feet of primary space
402.31 available for each person receiving services who is present at the site at any one time.

402.32 Primary space does not include:

403.1 (1) common areas, such as hallways, stairways, closets, utility areas, bathrooms,
403.2 and kitchens;

403.3 (2) floor areas beneath stationary equipment; or

403.4 (3) any space occupied by persons associated with the multifunctional organization
403.5 while persons receiving day services are using common space.

403.6 Subd. 2. **Individual personal articles.** Each person must be provided space in a
403.7 closet, cabinet, on a shelf, or a coat hook for storage of personal items for the person's own
403.8 use while receiving services at the facility, unless doing so would interfere with safety
403.9 precautions, another person's work space, or violate a building or fire code.

403.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

403.11 Sec. 45. **[245D.29] DAY SERVICES FACILITIES; HEALTH AND SAFETY**
403.12 **REQUIREMENTS.**

403.13 Subdivision 1. **Refrigeration.** If the license holder provides refrigeration at service
403.14 sites owned or leased by the license holder for storing perishable foods and perishable
403.15 portions of bag lunches, whether the foods are supplied by the license holder or the
403.16 persons receiving services, the refrigeration must have a temperature of 40 degrees
403.17 Fahrenheit or less.

403.18 Subd. 2. **Drinking water.** Drinking water must be available to all persons
403.19 receiving services. If a person is unable to request or obtain drinking water, it must be
403.20 provided according to that person's individual needs. Drinking water must be provided in
403.21 single-service containers or from drinking fountains accessible to all persons.

403.22 Subd. 3. **Individuals who become ill during the day.** There must be an area in
403.23 which a person receiving services can rest if:

403.24 (1) the person becomes ill during the day;

403.25 (2) the person does not live in a licensed residential site;

403.26 (3) the person requires supervision; and

403.27 (4) there is not a caretaker immediately available. Supervision must be provided
403.28 until the caretaker arrives to bring the person home.

403.29 Subd. 4. **Safety procedures.** The license holder must establish general written
403.30 safety procedures that include criteria for selecting, training, and supervising persons who
403.31 work with hazardous machinery, tools, or substances. Safety procedures specific to each
403.32 person's activities must be explained and be available in writing to all staff members
403.33 and persons receiving services.

403.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

404.1 Sec. 46. **[245D.31] DAY SERVICES FACILITIES; STAFF RATIO AND**
404.2 **FACILITY COVERAGE.**

404.3 Subdivision 1. **Scope.** This section applies only to facility-based day services.

404.4 Subd. 2. **Factors.** (a) The number of direct support service staff members that a
404.5 license holder must have on duty at the facility at a given time to meet the minimum
404.6 staffing requirements established in this section varies according to:

404.7 (1) the number of persons who are enrolled and receiving direct support services
404.8 at that given time;

404.9 (2) the staff ratio requirement established under subdivision 3 for each person who
404.10 is present; and

404.11 (3) whether the conditions described in subdivision 8 exist and warrant additional
404.12 staffing beyond the number determined to be needed under subdivision 7.

404.13 (b) The commissioner must consider the factors in paragraph (a) in determining a
404.14 license holder's compliance with the staffing requirements and must further consider
404.15 whether the staff ratio requirement established under subdivision 3 for each person
404.16 receiving services accurately reflects the person's need for staff time.

404.17 Subd. 3. **Staff ratio requirement for each person receiving services.** The case
404.18 manager, in consultation with the interdisciplinary team, must determine at least once each
404.19 year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving
404.20 services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio
404.21 assigned each person and the documentation of how the ratio was arrived at must be kept
404.22 in each person's individual service plan. Documentation must include an assessment of the
404.23 person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard
404.24 assessment form required by the commissioner.

404.25 Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a
404.26 staff ratio requirement of one to four if:

404.27 (1) on a daily basis the person requires total care and monitoring or constant
404.28 hand-over-hand physical guidance to successfully complete at least three of the following
404.29 activities: toileting, communicating basic needs, eating, ambulating; or is not capable of
404.30 taking appropriate action for self-preservation under emergency conditions; or

404.31 (2) the person engages in conduct that poses an imminent risk of physical harm to
404.32 self or others at a documented level of frequency, intensity, or duration requiring frequent
404.33 daily ongoing intervention and monitoring as established in the person's coordinated
404.34 service and support plan or coordinated service and support plan addendum.

404.35 Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a
404.36 staff ratio requirement of one to eight if:

405.1 (1) the person does not meet the requirements in subdivision 4; and
405.2 (2) on a daily basis the person requires verbal prompts or spot checks and minimal
405.3 or no physical assistance to successfully complete at least four of the following activities:
405.4 toileting, communicating basic needs, eating, ambulating, or taking appropriate action for
405.5 self-preservation under emergency conditions.

405.6 Subd. 6. **Person requiring staff ratio of one to six.** A person who does not have
405.7 any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio
405.8 requirement of one to six.

405.9 Subd. 7. **Determining number of direct support service staff required.** The
405.10 minimum number of direct support service staff members required at any one time to
405.11 meet the combined staff ratio requirements of the persons present at that time can be
405.12 determined by the following steps:

405.13 (1) assign to each person in attendance the three-digit decimal below that corresponds
405.14 to the staff ratio requirement assigned to that person. A staff ratio requirement of one to
405.15 four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio
405.16 requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

405.17 (2) add all of the three-digit decimals (one three-digit decimal for every person in
405.18 attendance) assigned in clause (1);

405.19 (3) when the sum in clause (2) falls between two whole numbers, round off the sum
405.20 to the larger of the two whole numbers; and

405.21 (4) the larger of the two whole numbers in clause (3) equals the number of direct
405.22 support service staff members needed to meet the staff ratio requirements of the persons
405.23 in attendance.

405.24 Subd. 8. **Staff to be included in calculating minimum staffing requirement.**
405.25 Only staff providing direct support must be counted as staff members in calculating
405.26 the staff-to-participant ratio. A volunteer may be counted as a direct support staff in
405.27 calculating the staff-to-participant ratio if the volunteer meets the same standards and
405.28 requirements as paid staff. No person receiving services must be counted as or be
405.29 substituted for a staff member in calculating the staff-to-participant ratio.

405.30 Subd. 9. **Conditions requiring additional direct support staff.** The license holder
405.31 must increase the number of direct support staff members present at any one time beyond
405.32 the number arrived at in subdivision 4 if necessary when any one or combination of the
405.33 following circumstances can be documented by the commissioner as existing:

405.34 (1) the health and safety needs of the persons receiving services cannot be met by
405.35 the number of staff members available under the staffing pattern in effect even though the
405.36 number has been accurately calculated under subdivision 7; or

406.1 (2) the person's conduct frequently presents an imminent risk of physical harm to
406.2 self or others.

406.3 Subd. 10. **Supervision requirements.** (a) At no time must one direct support
406.4 staff member be assigned responsibility for supervision and training of more than ten
406.5 persons receiving supervision and training, except as otherwise stated in each person's risk
406.6 management plan.

406.7 (b) In the temporary absence of the director or a supervisor, a direct support staff
406.8 member must be designated to supervise the center.

406.9 Subd. 11. **Multifunctional programs.** A multifunctional program may count other
406.10 employees of the organization besides direct support staff of the day service facility in
406.11 calculating the staff-to-participant ratio if the employee is assigned to the day services
406.12 facility for a specified amount of time, during which the employee is not assigned to
406.13 another organization or program.

406.14 **EFFECTIVE DATE.** This section is effective January 1, 2014.

406.15 Sec. 47. **[245D.32] ALTERNATIVE LICENSING INSPECTIONS.**

406.16 Subdivision 1. **Eligibility for an alternative licensing inspection.** (a) A license
406.17 holder providing services licensed under this chapter, with a qualifying accreditation and
406.18 meeting the eligibility criteria in paragraphs (b) and (c), may request approval for an
406.19 alternative licensing inspection when all services provided under the license holder's
406.20 license are accredited. A license holder with a qualifying accreditation and meeting
406.21 the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative
406.22 licensing inspection for individual community residential settings or day services facilities
406.23 licensed under this chapter.

406.24 (b) In order to be eligible for an alternative licensing inspection, the program must
406.25 have had at least one inspection by the commissioner following issuance of the initial
406.26 license. For programs operating a day services facility, each facility must have had at least
406.27 one on-site inspection by the commissioner following issuance of the initial license.

406.28 (c) In order to be eligible for an alternative licensing inspection, the program must
406.29 have been in substantial and consistent compliance at the time of the last licensing
406.30 inspection and during the current licensing period. For purposes of this section,
406.31 "substantial and consistent compliance" means:

406.32 (1) the license holder's license was not made conditional, suspended, or revoked;

406.33 (2) there have been no substantiated allegations of maltreatment against the license
406.34 holder;

407.1 (3) there were no program deficiencies identified that would jeopardize the health,
407.2 safety, or rights of persons being served; and

407.3 (4) the license holder maintained substantial compliance with the other requirements
407.4 of chapters 245A and 245C and other applicable laws and rules.

407.5 (d) For the purposes of this section, the license holder's license includes services
407.6 licensed under this chapter that were previously licensed under chapter 245B until
407.7 December 31, 2013.

407.8 Subd. 2. **Qualifying accreditation.** The commissioner must accept a three-year
407.9 accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)
407.10 as a qualifying accreditation.

407.11 Subd. 3. **Request for approval of an alternative inspection status.** (a) A request
407.12 for an alternative inspection must be made on the forms and in the manner prescribed
407.13 by the commissioner. When submitting the request, the license holder must submit all
407.14 documentation issued by the accrediting body verifying that the license holder has obtained
407.15 and maintained the qualifying accreditation and has complied with recommendations
407.16 or requirements from the accrediting body during the period of accreditation. Based
407.17 on the request and the additional required materials, the commissioner may approve
407.18 an alternative inspection status.

407.19 (b) The commissioner must notify the license holder in writing that the request for
407.20 an alternative inspection status has been approved. Approval must be granted until the
407.21 end of the qualifying accreditation period.

407.22 (c) The license holder must submit a written request for approval to be renewed
407.23 one month before the end of the current approval period according to the requirements
407.24 in paragraph (a). If the license holder does not submit a request to renew approval as
407.25 required, the commissioner must conduct a licensing inspection.

407.26 Subd. 4. **Programs approved for alternative licensing inspection; deemed**
407.27 **compliance licensing requirements.** (a) A license holder approved for alternative
407.28 licensing inspection under this section is required to maintain compliance with all
407.29 licensing standards according to this chapter.

407.30 (b) A license holder approved for alternative licensing inspection under this section
407.31 must be deemed to be in compliance with all the requirements of this chapter, and the
407.32 commissioner must not perform routine licensing inspections.

407.33 (c) Upon receipt of a complaint regarding the services of a license holder approved
407.34 for alternative licensing inspection under this section, the commissioner must investigate
407.35 the complaint and may take any action as provided under section 245A.06 or 245A.07.

408.1 Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this
408.2 section changes the commissioner's responsibilities to investigate alleged or suspected
408.3 maltreatment of a minor under section 626.556 or a vulnerable adult under section 626.557.

408.4 Subd. 6. **Termination or denial of subsequent approval.** Following approval of
408.5 an alternative licensing inspection, the commissioner may terminate or deny subsequent
408.6 approval of an alternative licensing inspection if the commissioner determines that:

408.7 (1) the license holder has not maintained the qualifying accreditation;

408.8 (2) the commissioner has substantiated maltreatment for which the license holder or
408.9 facility is determined to be responsible during the qualifying accreditation period; or

408.10 (3) during the qualifying accreditation period, the license holder has been issued
408.11 an order for conditional license, fine, suspension, or license revocation that has not been
408.12 reversed upon appeal.

408.13 Subd. 7. **Appeals.** The commissioner's decision that the conditions for approval for
408.14 an alternative licensing inspection have not been met is final and not subject to appeal
408.15 under the provisions of chapter 14.

408.16 Subd. 8. **Commissioner's programs.** Home and community-based services licensed
408.17 under this chapter for which the commissioner is the license holder with a qualifying
408.18 accreditation are excluded from being approved for an alternative licensing inspection.

408.19 **EFFECTIVE DATE.** This section is effective January 1, 2014.

408.20 Sec. 48. **[245D.33] ADULT MENTAL HEALTH CERTIFICATION STANDARDS.**

408.21 (a) The commissioner of human services shall issue a mental health certification
408.22 for services licensed under this chapter when a license holder is determined to have met
408.23 the requirements under paragraph (b). This certification is voluntary for license holders.
408.24 The certification shall be printed on the license and identified on the commissioner's
408.25 public Web site.

408.26 (b) The requirements for certification are:

408.27 (1) all staff have received at least seven hours of annual training covering all of
408.28 the following topics:

408.29 (i) mental health diagnoses;

408.30 (ii) mental health crisis response and de-escalation techniques;

408.31 (iii) recovery from mental illness;

408.32 (iv) treatment options, including evidence-based practices;

408.33 (v) medications and their side effects;

408.34 (vi) co-occurring substance abuse and health conditions; and

408.35 (vii) community resources;

409.1 (2) a mental health professional, as defined in section 245.462, subdivision 18, or a
409.2 mental health practitioner as defined in section 245.462, subdivision 17, is available
409.3 for consultation and assistance;

409.4 (3) there is a plan and protocol in place to address a mental health crisis; and

409.5 (4) each person's individual service and support plan identifies who is providing
409.6 clinical services and their contact information, and includes an individual crisis prevention
409.7 and management plan developed with the person.

409.8 (c) License holders seeking certification under this section must request this
409.9 certification on forms and in the manner prescribed by the commissioner.

409.10 (d) If the commissioner finds that the license holder has failed to comply with the
409.11 certification requirements under paragraph (b), the commissioner may issue a correction
409.12 order and an order of conditional license in accordance with section 245A.06 or may
409.13 issue a sanction in accordance with section 245A.07, including and up to removal of
409.14 the certification.

409.15 (e) A denial of the certification or the removal of the certification based on a
409.16 determination that the requirements under paragraph (b) have not been met is not subject to
409.17 appeal. A license holder that has been denied a certification or that has had a certification
409.18 removed may again request certification when the license holder is in compliance with the
409.19 requirements of paragraph (b).

409.20 **EFFECTIVE DATE.** This section is effective January 1, 2014.

409.21 Sec. 49. Minnesota Statutes 2012, section 256B.092, subdivision 1a, is amended to read:

409.22 Subd. 1a. **Case management services.** (a) Each recipient of a home and
409.23 community-based waiver shall be provided case management services by qualified
409.24 vendors as described in the federally approved waiver application.

409.25 (b) Case management service activities provided to or arranged for a person include:

409.26 (1) development of the coordinated service and support plan under subdivision 1b;

409.27 (2) informing the individual or the individual's legal guardian or conservator, or
409.28 parent if the person is a minor, of service options;

409.29 (3) consulting with relevant medical experts or service providers;

409.30 (4) assisting the person in the identification of potential providers;

409.31 (5) assisting the person to access services and assisting in appeals under section
409.32 256.045;

409.33 (6) coordination of services, if coordination is not provided by another service
409.34 provider;

410.1 (7) evaluation and monitoring of the services identified in the coordinated service
410.2 and support plan, which must incorporate at least one annual face-to-face visit by the case
410.3 manager with each person; and

410.4 (8) reviewing coordinated service and support plans and providing the lead agency
410.5 with recommendations for service authorization based upon the individual's needs
410.6 identified in the coordinated service and support plan.

410.7 (c) Case management service activities that are provided to the person with a
410.8 developmental disability shall be provided directly by county agencies or under contract.
410.9 Case management services must be provided by a public or private agency that is enrolled
410.10 as a medical assistance provider determined by the commissioner to meet all of the
410.11 requirements in the approved federal waiver plans. Case management services must not
410.12 be provided to a recipient by a private agency that has a financial interest in the provision
410.13 of any other services included in the recipient's coordinated service and support plan. For
410.14 purposes of this section, "private agency" means any agency that is not identified as a lead
410.15 agency under section 256B.0911, subdivision 1a, paragraph (e).

410.16 (d) Case managers are responsible for service provisions listed in paragraphs (a) and
410.17 (b). Case managers shall collaborate with consumers, families, legal representatives, and
410.18 relevant medical experts and service providers in the development and annual review of
410.19 the coordinated service and support plan and habilitation plan.

410.20 (e) For persons who need a positive support transition plan as required in chapter
410.21 245D, the case manager shall participate in the development and ongoing evaluation
410.22 of the plan with the expanded support team. At least quarterly, the case manager, in
410.23 consultation with the expanded support team, shall evaluate the effectiveness of the plan
410.24 based on progress evaluation data submitted by the licensed provider to the case manager.
410.25 The evaluation must identify whether the plan has been developed and implemented in a
410.26 manner to achieve the following within the required timelines:

410.27 (1) phasing out the use of prohibited procedures;

410.28 (2) acquisition of skills needed to eliminate the prohibited procedures within the
410.29 plan's timeline; and

410.30 (3) accomplishment of identified outcomes.

410.31 If adequate progress is not being made, the case manager shall consult with the person's
410.32 expanded support team to identify needed modifications and whether additional
410.33 professional support is required to provide consultation.

410.34 (e) (f) The Department of Human Services shall offer ongoing education in case
410.35 management to case managers. Case managers shall receive no less than ten hours of case
410.36 management education and disability-related training each year.

411.1 **EFFECTIVE DATE.** This section is effective January 1, 2014.

411.2 Sec. 50. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

411.3 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
411.4 established a new service called residential support that is available on the community
411.5 alternative care, community alternatives for disabled individuals, developmental
411.6 disabilities, and brain injury waivers. Existing waiver service descriptions must be
411.7 modified to the extent necessary to ensure there is no duplication between other services.
411.8 Residential support services must be provided by vendors licensed as a community
411.9 residential setting as defined in section 245A.11, subdivision 8, a foster care setting
411.10 licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care
411.11 setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

411.12 (b) Residential support services must meet the following criteria:

411.13 ~~(1) providers of residential support services must own or control the residential site;~~

411.14 ~~(2) the residential site must not be the primary residence of the license holder;~~

411.15 ~~(3)~~ (1) the residential site must have a designated program supervisor person
411.16 responsible for program management, oversight, development, and implementation of
411.17 policies and procedures;

411.18 ~~(4)~~ (2) the provider of residential support services must provide supervision, training,
411.19 and assistance as described in the person's coordinated service and support plan; and

411.20 ~~(5)~~ (3) the provider of residential support services must meet the requirements of
411.21 licensure and additional requirements of the person's coordinated service and support plan.

411.22 (c) Providers of residential support services that meet the definition in paragraph (a)
411.23 ~~must be registered using a process determined by the commissioner beginning July 1, 2009~~
411.24 must be licensed according to chapter 245D. Providers licensed to provide child foster care
411.25 under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under
411.26 Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section
411.27 245A.03, subdivision 7, paragraph (g), are considered registered under this section.

411.28 Sec. 51. Minnesota Statutes 2012, section 256B.49, subdivision 13, is amended to read:

411.29 Subd. 13. **Case management.** (a) Each recipient of a home and community-based
411.30 waiver shall be provided case management services by qualified vendors as described
411.31 in the federally approved waiver application. The case management service activities
411.32 provided must include:

411.33 (1) finalizing the written coordinated service and support plan within ten working
411.34 days after the case manager receives the plan from the certified assessor;

412.1 (2) informing the recipient or the recipient's legal guardian or conservator of service
412.2 options;

412.3 (3) assisting the recipient in the identification of potential service providers and
412.4 available options for case management service and providers;

412.5 (4) assisting the recipient to access services and assisting with appeals under section
412.6 256.045; and

412.7 (5) coordinating, evaluating, and monitoring of the services identified in the service
412.8 plan.

412.9 (b) The case manager may delegate certain aspects of the case management service
412.10 activities to another individual provided there is oversight by the case manager. The case
412.11 manager may not delegate those aspects which require professional judgment including:

412.12 (1) finalizing the coordinated service and support plan;

412.13 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
412.14 approved coordinated service and support plan; and

412.15 (3) adjustments to the coordinated service and support plan.

412.16 (c) Case management services must be provided by a public or private agency that is
412.17 enrolled as a medical assistance provider determined by the commissioner to meet all of
412.18 the requirements in the approved federal waiver plans. Case management services must
412.19 not be provided to a recipient by a private agency that has any financial interest in the
412.20 provision of any other services included in the recipient's coordinated service and support
412.21 plan. For purposes of this section, "private agency" means any agency that is not identified
412.22 as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

412.23 (d) For persons who need a positive support transition plan as required in chapter
412.24 245D, the case manager shall participate in the development and ongoing evaluation
412.25 of the plan with the expanded support team. At least quarterly, the case manager, in
412.26 consultation with the expanded support team, shall evaluate the effectiveness of the plan
412.27 based on progress evaluation data submitted by the licensed provider to the case manager.
412.28 The evaluation must identify whether the plan has been developed and implemented in a
412.29 manner to achieve the following within the required timelines:

412.30 (1) phasing out the use of prohibited procedures;

412.31 (2) acquisition of skills needed to eliminate the prohibited procedures within the
412.32 plan's timeline; and

412.33 (3) accomplishment of identified outcomes.

412.34 If adequate progress is not being made, the case manager shall consult with the person's
412.35 expanded support team to identify needed modifications and whether additional
412.36 professional support is required to provide consultation.

413.1 **EFFECTIVE DATE.** This section is effective January 1, 2014.

413.2 Sec. 52. Minnesota Statutes 2012, section 256B.4912, subdivision 1, is amended to read:

413.3 Subdivision 1. **Provider qualifications.** (a) For the home and community-based
413.4 waivers providing services to seniors and individuals with disabilities under sections
413.5 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

413.6 (1) agreements with enrolled waiver service providers to ensure providers meet
413.7 Minnesota health care program requirements;

413.8 (2) regular reviews of provider qualifications, and including requests of proof of
413.9 documentation; and

413.10 (3) processes to gather the necessary information to determine provider qualifications.

413.11 (b) Beginning July 1, 2012, staff that provide direct contact, as defined in section
413.12 245C.02, subdivision 11, for services specified in the federally approved waiver plans
413.13 must meet the requirements of chapter 245C prior to providing waiver services and as
413.14 part of ongoing enrollment. Upon federal approval, this requirement must also apply to
413.15 consumer-directed community supports.

413.16 (c) Beginning January 1, 2014, service owners and managerial officials overseeing
413.17 the management or policies of services that provide direct contact as specified in the
413.18 federally approved waiver plans must meet the requirements of chapter 245C prior to
413.19 reenrollment or, for new providers, prior to initial enrollment if they have not already done
413.20 so as a part of service licensure requirements.

413.21 Sec. 53. Minnesota Statutes 2012, section 256B.4912, subdivision 7, is amended to read:

413.22 Subd. 7. **Applicant and license holder training.** An applicant or license holder
413.23 for the home and community-based waivers providing services to seniors and individuals
413.24 with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is
413.25 not enrolled as a Minnesota health care program home and community-based services
413.26 waiver provider at the time of application must ensure that at least one controlling
413.27 individual completes a onetime training on the requirements for providing home and
413.28 community-based services ~~from a qualified source~~ as determined by the commissioner,
413.29 before a provider is enrolled or license is issued. Within six months of enrollment, a
413.30 newly enrolled home and community-based waiver service provider must ensure that at
413.31 least one controlling individual has completed training on waiver and related program
413.32 billing. Exemptions to new waiver provider training requirements may be granted, as
413.33 determined by the commissioner.

414.1 Sec. 54. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
414.2 subdivision to read:

414.3 Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1,
414.4 2013, facilities and services to be licensed under chapter 245D shall submit data regarding
414.5 the use of emergency use of manual restraint as identified in section 245D.061 in a format
414.6 and at a frequency identified by the commissioner.

414.7 Sec. 55. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
414.8 subdivision to read:

414.9 Subd. 9. **Definitions.** (a) For the purposes of this section, the following terms
414.10 have the meanings given them.

414.11 (b) "Controlling individual" means a public body, governmental agency, business
414.12 entity, officer, owner, or managerial official whose responsibilities include the direction of
414.13 the management or policies of a program.

414.14 (c) "Managerial official" means an individual who has decision-making authority
414.15 related to the operation of the program and responsibility for the ongoing management of
414.16 or direction of the policies, services, or employees of the program.

414.17 (d) "Owner" means an individual who has direct or indirect ownership interest in
414.18 a corporation or partnership, or business association enrolling with the Department of
414.19 Human Services as a provider of waiver services.

414.20 Sec. 56. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
414.21 subdivision to read:

414.22 Subd. 10. **Enrollment requirements.** All home and community-based waiver
414.23 providers must provide, at the time of enrollment and within 30 days of a request, in a
414.24 format determined by the commissioner, information and documentation that includes, but
414.25 is not limited to, the following:

414.26 (1) proof of surety bond coverage in the amount of \$50,000 or ten percent of the
414.27 provider's payments from Medicaid in the previous calendar year, whichever is greater;

414.28 (2) proof of fidelity bond coverage in the amount of \$20,000; and

414.29 (3) proof of liability insurance.

414.30 Sec. 57. Minnesota Statutes 2012, section 626.557, subdivision 9a, is amended to read:

414.31 **Subd. 9a. Evaluation and referral of reports made to common entry point unit.**

414.32 The common entry point must screen the reports of alleged or suspected maltreatment for
414.33 immediate risk and make all necessary referrals as follows:

415.1 (1) if the common entry point determines that there is an immediate need for
415.2 adult protective services, the common entry point agency shall immediately notify the
415.3 appropriate county agency;

415.4 (2) if the report contains suspected criminal activity against a vulnerable adult, the
415.5 common entry point shall immediately notify the appropriate law enforcement agency;

415.6 (3) the common entry point shall refer all reports of alleged or suspected
415.7 maltreatment to the appropriate lead investigative agency as soon as possible, but in any
415.8 event no longer than two working days; and

415.9 ~~(4) if the report involves services licensed by the Department of Human Services~~
415.10 ~~and subject to chapter 245D, the common entry point shall refer the report to the county as~~
415.11 ~~the lead agency according to clause (3), but shall also notify the Department of Human~~
415.12 ~~Services of the report; and~~

415.13 ~~(5)~~ (4) if the report contains information about a suspicious death, the common
415.14 entry point shall immediately notify the appropriate law enforcement agencies, the local
415.15 medical examiner, and the ombudsman for mental health and developmental disabilities
415.16 established under section 245.92. Law enforcement agencies shall coordinate with the
415.17 local medical examiner and the ombudsman as provided by law.

415.18 Sec. 58. Minnesota Statutes 2012, section 626.5572, subdivision 13, is amended to read:

415.19 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
415.20 administrative agency responsible for investigating reports made under section 626.557.

415.21 (a) The Department of Health is the lead investigative agency for facilities or
415.22 services licensed or required to be licensed as hospitals, home care providers, nursing
415.23 homes, boarding care homes, hospice providers, residential facilities that are also federally
415.24 certified as intermediate care facilities that serve people with developmental disabilities,
415.25 or any other facility or service not listed in this subdivision that is licensed or required to
415.26 be licensed by the Department of Health for the care of vulnerable adults. "Home care
415.27 provider" has the meaning provided in section 144A.43, subdivision 4, and applies when
415.28 care or services are delivered in the vulnerable adult's home, whether a private home or a
415.29 housing with services establishment registered under chapter 144D, including those that
415.30 offer assisted living services under chapter 144G.

415.31 ~~(b) Except as provided under paragraph (c), for services licensed according to chapter~~
415.32 ~~245D, The Department of Human Services is the lead investigative agency for facilities or~~
415.33 ~~services licensed or required to be licensed as adult day care, adult foster care, community~~
415.34 ~~residential settings, programs for people with developmental disabilities, family adult day~~
415.35 ~~services, mental health programs, mental health clinics, chemical dependency programs,~~

416.1 the Minnesota sex offender program, or any other facility or service not listed in this
416.2 subdivision that is licensed or required to be licensed by the Department of Human Services.

416.3 (c) The county social service agency or its designee is the lead investigative agency
416.4 for all other reports, including, but not limited to, reports involving vulnerable adults
416.5 receiving services from a personal care provider organization under section 256B.0659;
416.6 ~~or receiving home and community-based services licensed by the Department of Human~~
416.7 ~~Services and subject to chapter 245D.~~

416.8 Sec. 59. **REPORT ON TRANSFER OF VULNERABLE ADULT**
416.9 **MALTREATMENT INVESTIGATION DUTIES.**

416.10 (a) The commissioner of human services shall provide a follow-up report on the
416.11 collection of fees and actual licensing and maltreatment investigation costs resulting from
416.12 the reform of the standards and oversight for home and community-based services as
416.13 adopted and funded by the 2013 legislature.

416.14 (b) The report must identify actual fees collected based on provider revenue,
416.15 distinguish the amount of fees collected based on non-medical assistance revenue, and
416.16 determine the impact of the non-medical assistance revenue on future licensing fees.

416.17 (c) The report must recommend how maltreatment investigations, when conducted
416.18 by the commissioner of human services, should be funded and at what amount. The
416.19 recommendation must identify whether maltreatment investigation costs should be
416.20 recovered through licensure fees, an appropriation from the general fund, provider
416.21 finances for substantiated maltreatment, licensing fee surcharges related to substantiated
416.22 maltreatment, or a combination of these sources.

416.23 (d) The report must contain a cost comparison between similar maltreatment
416.24 investigations completed by the Minnesota Department of Health and the Department of
416.25 Human Services, and describe the method of funding for the investigations conducted by
416.26 the Department of Health.

416.27 (e) The report must make recommendations for changes that the commissioner
416.28 determines are appropriate to reduce the costs of maltreatment investigations.

416.29 (f) The commissioner must submit the report with draft legislation proposing
416.30 alternative fees, if necessary, to the chairs and ranking minority members of the legislative
416.31 committees with jurisdiction over health and human services policy and finance by July
416.32 1, 2015.

416.33 Sec. 60. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
416.34 **AND COMMUNITY-BASED SERVICES.**

417.1 (a) The Department of Health Compliance Monitoring Division and the Department
417.2 of Human Services Licensing Division shall jointly develop an integrated licensing system
417.3 for providers of both home care services subject to licensure under Minnesota Statutes,
417.4 chapter 144A, and for home and community-based services subject to licensure under
417.5 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

417.6 (1) require only one license of any provider of services under Minnesota Statutes,
417.7 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

417.8 (2) promote quality services that recognize a person's individual needs and protect
417.9 the person's health, safety, rights, and well-being;

417.10 (3) promote provider accountability through application requirements, compliance
417.11 inspections, investigations, and enforcement actions;

417.12 (4) reference other applicable requirements in existing state and federal laws,
417.13 including the federal Affordable Care Act;

417.14 (5) establish internal procedures to facilitate ongoing communications between the
417.15 agencies and with providers and services recipients about the regulatory activities;

417.16 (6) create a link between the agency Web sites so that providers and the public can
417.17 access the same information regardless of which Web site is accessed initially; and

417.18 (7) collect data on identified outcome measures as necessary for the agencies to
417.19 report to the Centers for Medicare and Medicaid Services.

417.20 (b) The joint recommendations for legislative changes to implement the integrated
417.21 licensing system are due to the legislature by February 15, 2014.

417.22 (c) Before implementation of the integrated licensing system, providers licensed as
417.23 home care providers under Minnesota Statutes, chapter 144A, may also provide home
417.24 and community-based services subject to licensure under Minnesota Statutes, chapter
417.25 245D, without obtaining a home and community-based services license under Minnesota
417.26 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
417.27 apply to these providers:

417.28 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
417.29 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

417.30 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
417.31 enforced by the Department of Health under the enforcement authority set forth in
417.32 Minnesota Statutes, section 144A.475; and

417.33 (3) the Department of Health will provide information to the Department of Human
417.34 Services about each provider licensed under this section, including the provider's license
417.35 application, licensing documents, inspections, information about complaints received, and
417.36 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

418.1 Sec. 61. **REPEALER.**

418.2 (a) Minnesota Statutes 2012, sections 245B.01; 245B.02; 245B.03; 245B.031;
418.3 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, and 7; 245B.055; 245B.06; 245B.07; and
418.4 245B.08, are repealed effective January 1, 2014.

418.5 (b) Minnesota Statutes 2012, section 245D.08, is repealed.

418.6 **ARTICLE 9**

418.7 **WAIVER PROVIDER STANDARDS TECHNICAL CHANGES**

418.8 Section 1. Minnesota Statutes 2012, section 16C.10, subdivision 5, is amended to read:

418.9 Subd. 5. **Specific purchases.** The solicitation process described in this chapter is
418.10 not required for acquisition of the following:

418.11 (1) merchandise for resale purchased under policies determined by the commissioner;

418.12 (2) farm and garden products which, as determined by the commissioner, may be
418.13 purchased at the prevailing market price on the date of sale;

418.14 (3) goods and services from the Minnesota correctional facilities;

418.15 (4) goods and services from rehabilitation facilities and extended employment
418.16 providers that are certified by the commissioner of employment and economic

418.17 development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01~~
418.18 ~~to 245B.08~~ chapter 245D;

418.19 (5) goods and services for use by a community-based facility operated by the
418.20 commissioner of human services;

418.21 (6) goods purchased at auction or when submitting a sealed bid at auction provided
418.22 that before authorizing such an action, the commissioner consult with the requesting
418.23 agency to determine a fair and reasonable value for the goods considering factors
418.24 including, but not limited to, costs associated with submitting a bid, travel, transportation,
418.25 and storage. This fair and reasonable value must represent the limit of the state's bid;

418.26 (7) utility services where no competition exists or where rates are fixed by law or
418.27 ordinance; and

418.28 (8) goods and services from Minnesota sex offender program facilities.

418.29 **EFFECTIVE DATE.** This section is effective January 1, 2014.

418.30 Sec. 2. Minnesota Statutes 2012, section 16C.155, subdivision 1, is amended to read:

418.31 Subdivision 1. **Service contracts.** The commissioner of administration shall
418.32 ensure that a portion of all contracts for janitorial services; document imaging;
418.33 document shredding; and mailing, collating, and sorting services be awarded by the
418.34 state to rehabilitation programs and extended employment providers that are certified

419.1 by the commissioner of employment and economic development, and day ~~training and~~
419.2 ~~habilitation~~ services licensed under sections ~~245B.01 to 245B.08~~ chapter 245D. The
419.3 amount of each contract awarded under this section may exceed the estimated fair market
419.4 price as determined by the commissioner for the same goods and services by up to six
419.5 percent. The aggregate value of the contracts awarded to eligible providers under this
419.6 section in any given year must exceed 19 percent of the total value of all contracts for
419.7 janitorial services; document imaging; document shredding; and mailing, collating, and
419.8 sorting services entered into in the same year. For the 19 percent requirement to be
419.9 applicable in any given year, the contract amounts proposed by eligible providers must be
419.10 within six percent of the estimated fair market price for at least 19 percent of the contracts
419.11 awarded for the corresponding service area.

419.12 **EFFECTIVE DATE.** This section is effective January 1, 2014.

419.13 Sec. 3. Minnesota Statutes 2012, section 144D.01, subdivision 4, is amended to read:

419.14 Subd. 4. **Housing with services establishment or establishment.** (a) "Housing
419.15 with services establishment" or "establishment" means:

419.16 (1) an establishment providing sleeping accommodations to one or more adult
419.17 residents, at least 80 percent of which are 55 years of age or older, and offering or
419.18 providing, for a fee, one or more regularly scheduled health-related services or two or
419.19 more regularly scheduled supportive services, whether offered or provided directly by the
419.20 establishment or by another entity arranged for by the establishment; or

419.21 (2) an establishment that registers under section 144D.025.

419.22 (b) Housing with services establishment does not include:

419.23 (1) a nursing home licensed under chapter 144A;

419.24 (2) a hospital, certified boarding care home, or supervised living facility licensed
419.25 under sections 144.50 to 144.56;

419.26 (3) a board and lodging establishment licensed under chapter 157 and Minnesota
419.27 Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660,
419.28 or 9530.4100 to 9530.4450, or under chapter ~~245B~~ 245D;

419.29 (4) a board and lodging establishment which serves as a shelter for battered women
419.30 or other similar purpose;

419.31 (5) a family adult foster care home licensed by the Department of Human Services;

419.32 (6) private homes in which the residents are related by kinship, law, or affinity with
419.33 the providers of services;

420.1 (7) residential settings for persons with developmental disabilities in which the
420.2 services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable
420.3 successor rules or laws;

420.4 (8) a home-sharing arrangement such as when an elderly or disabled person or
420.5 single-parent family makes lodging in a private residence available to another person
420.6 in exchange for services or rent, or both;

420.7 (9) a duly organized condominium, cooperative, common interest community, or
420.8 owners' association of the foregoing where at least 80 percent of the units that comprise the
420.9 condominium, cooperative, or common interest community are occupied by individuals
420.10 who are the owners, members, or shareholders of the units; or

420.11 (10) services for persons with developmental disabilities that are provided under
420.12 a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until
420.13 January 1, 1998, or under chapter ~~245B~~ 245D.

420.14 **EFFECTIVE DATE.** This section is effective January 1, 2014.

420.15 Sec. 4. Minnesota Statutes 2012, section 174.30, subdivision 1, is amended to read:

420.16 Subdivision 1. **Applicability.** (a) The operating standards for special transportation
420.17 service adopted under this section do not apply to special transportation provided by:

420.18 (1) a common carrier operating on fixed routes and schedules;

420.19 (2) a volunteer driver using a private automobile;

420.20 (3) a school bus as defined in section 169.011, subdivision 71; or

420.21 (4) an emergency ambulance regulated under chapter 144.

420.22 (b) The operating standards adopted under this section only apply to providers
420.23 of special transportation service who receive grants or other financial assistance from
420.24 either the state or the federal government, or both, to provide or assist in providing that
420.25 service; except that the operating standards adopted under this section do not apply
420.26 to any nursing home licensed under section 144A.02, to any board and care facility
420.27 licensed under section 144.50, or to any day training and habilitation services, day care,
420.28 or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or
420.29 program provides transportation to nonresidents on a regular basis and the facility receives
420.30 reimbursement, other than per diem payments, for that service under rules promulgated
420.31 by the commissioner of human services.

420.32 (c) Notwithstanding paragraph (b), the operating standards adopted under this
420.33 section do not apply to any vendor of services licensed under chapter ~~245B~~ 245D that
420.34 provides transportation services to consumers or residents of other vendors licensed under

421.1 chapter ~~245B~~ 245D and transports 15 or fewer persons, including consumers or residents
421.2 and the driver.

421.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

421.4 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 1, is amended to read:

421.5 Subdivision 1. **Scope.** The terms used in this chapter ~~and chapter 245B~~ have the
421.6 meanings given them in this section.

421.7 **EFFECTIVE DATE.** This section is effective January 1, 2014.

421.8 Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 9, is amended to read:

421.9 Subd. 9. **License holder.** "License holder" means an individual, corporation,
421.10 partnership, voluntary association, or other organization that is legally responsible for the
421.11 operation of the program, has been granted a license by the commissioner under this chapter
421.12 or chapter ~~245B~~ 245D and the rules of the commissioner, and is a controlling individual.

421.13 **EFFECTIVE DATE.** This section is effective January 1, 2014.

421.14 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

421.15 Subd. 9. **Permitted services by an individual who is related.** Notwithstanding
421.16 subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a
421.17 person receiving supported living services may provide licensed services to that person if:

421.18 (1) the person who receives supported living services received these services in a
421.19 residential site on July 1, 2005;

421.20 (2) the services under clause (1) were provided in a corporate foster care setting for
421.21 adults and were funded by the developmental disabilities home and community-based
421.22 services waiver defined in section 256B.092;

421.23 (3) the individual who is related obtains and maintains both a license under chapter
421.24 ~~245B~~ 245D and an adult foster care license under Minnesota Rules, parts 9555.5105
421.25 to 9555.6265; and

421.26 (4) the individual who is related is not the guardian of the person receiving supported
421.27 living services.

421.28 **EFFECTIVE DATE.** This section is effective January 1, 2014.

421.29 Sec. 8. Minnesota Statutes 2012, section 245A.04, subdivision 13, is amended to read:

422.1 Subd. 13. **Funds and property; other requirements.** (a) A license holder must
422.2 ensure that persons served by the program retain the use and availability of personal funds
422.3 or property unless restrictions are justified in the person's individual plan. ~~This subdivision~~
422.4 ~~does not apply to programs governed by the provisions in section 245B.07, subdivision 10.~~

422.5 (b) The license holder must ensure separation of funds of persons served by the
422.6 program from funds of the license holder, the program, or program staff.

422.7 (c) Whenever the license holder assists a person served by the program with the
422.8 safekeeping of funds or other property, the license holder must:

422.9 (1) immediately document receipt and disbursement of the person's funds or other
422.10 property at the time of receipt or disbursement, including the person's signature, or the
422.11 signature of the conservator or payee; and

422.12 (2) return to the person upon the person's request, funds and property in the license
422.13 holder's possession subject to restrictions in the person's treatment plan, as soon as
422.14 possible, but no later than three working days after the date of request.

422.15 (d) License holders and program staff must not:

422.16 (1) borrow money from a person served by the program;

422.17 (2) purchase personal items from a person served by the program;

422.18 (3) sell merchandise or personal services to a person served by the program;

422.19 (4) require a person served by the program to purchase items for which the license
422.20 holder is eligible for reimbursement; or

422.21 (5) use funds of persons served by the program to purchase items for which the
422.22 facility is already receiving public or private payments.

422.23 **EFFECTIVE DATE.** This section is effective January 1, 2014.

422.24 Sec. 9. Minnesota Statutes 2012, section 245A.07, subdivision 3, is amended to read:

422.25 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may
422.26 suspend or revoke a license, or impose a fine if:

422.27 (1) a license holder fails to comply fully with applicable laws or rules;

422.28 (2) a license holder, a controlling individual, or an individual living in the household
422.29 where the licensed services are provided or is otherwise subject to a background study has
422.30 a disqualification which has not been set aside under section 245C.22;

422.31 (3) a license holder knowingly withholds relevant information from or gives false
422.32 or misleading information to the commissioner in connection with an application for
422.33 a license, in connection with the background study status of an individual, during an
422.34 investigation, or regarding compliance with applicable laws or rules; or

423.1 (4) after July 1, 2012, and upon request by the commissioner, a license holder fails
423.2 to submit the information required of an applicant under section 245A.04, subdivision 1,
423.3 paragraph (f) or (g).

423.4 A license holder who has had a license suspended, revoked, or has been ordered
423.5 to pay a fine must be given notice of the action by certified mail or personal service. If
423.6 mailed, the notice must be mailed to the address shown on the application or the last
423.7 known address of the license holder. The notice must state the reasons the license was
423.8 suspended, revoked, or a fine was ordered.

423.9 (b) If the license was suspended or revoked, the notice must inform the license
423.10 holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
423.11 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
423.12 a license. The appeal of an order suspending or revoking a license must be made in writing
423.13 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
423.14 the commissioner within ten calendar days after the license holder receives notice that the
423.15 license has been suspended or revoked. If a request is made by personal service, it must be
423.16 received by the commissioner within ten calendar days after the license holder received
423.17 the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits
423.18 a timely appeal of an order suspending or revoking a license, the license holder may
423.19 continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs
423.20 (g) and (h), until the commissioner issues a final order on the suspension or revocation.

423.21 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the
423.22 license holder of the responsibility for payment of fines and the right to a contested case
423.23 hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal
423.24 of an order to pay a fine must be made in writing by certified mail or personal service. If
423.25 mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
423.26 days after the license holder receives notice that the fine has been ordered. If a request is
423.27 made by personal service, it must be received by the commissioner within ten calendar
423.28 days after the license holder received the order.

423.29 (2) The license holder shall pay the fines assessed on or before the payment date
423.30 specified. If the license holder fails to fully comply with the order, the commissioner
423.31 may issue a second fine or suspend the license until the license holder complies. If the
423.32 license holder receives state funds, the state, county, or municipal agencies or departments
423.33 responsible for administering the funds shall withhold payments and recover any payments
423.34 made while the license is suspended for failure to pay a fine. A timely appeal shall stay
423.35 payment of the fine until the commissioner issues a final order.

424.1 (3) A license holder shall promptly notify the commissioner of human services,
424.2 in writing, when a violation specified in the order to forfeit a fine is corrected. If upon
424.3 reinspection the commissioner determines that a violation has not been corrected as
424.4 indicated by the order to forfeit a fine, the commissioner may issue a second fine. The
424.5 commissioner shall notify the license holder by certified mail or personal service that a
424.6 second fine has been assessed. The license holder may appeal the second fine as provided
424.7 under this subdivision.

424.8 (4) Fines shall be assessed as follows: the license holder shall forfeit \$1,000 for
424.9 each determination of maltreatment of a child under section 626.556 or the maltreatment
424.10 of a vulnerable adult under section 626.557 for which the license holder is determined
424.11 responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i),
424.12 or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit \$200 for each
424.13 occurrence of a violation of law or rule governing matters of health, safety, or supervision,
424.14 including but not limited to the provision of adequate staff-to-child or adult ratios, and
424.15 failure to comply with background study requirements under chapter 245C; and the license
424.16 holder shall forfeit \$100 for each occurrence of a violation of law or rule other than
424.17 those subject to a \$1,000 or \$200 fine above. For purposes of this section, "occurrence"
424.18 means each violation identified in the commissioner's fine order. Fines assessed against a
424.19 license holder that holds a license to provide ~~the residential-based habilitation home and~~
424.20 community-based services, as defined under identified in section 245B.02, subdivision
424.21 20 245D.03, subdivision 1, and a community residential setting or day services facility
424.22 license to provide foster care under chapter 245D where the services are provided, may be
424.23 assessed against both licenses for the same occurrence, but the combined amount of the
424.24 fines shall not exceed the amount specified in this clause for that occurrence.

424.25 (5) When a fine has been assessed, the license holder may not avoid payment by
424.26 closing, selling, or otherwise transferring the licensed program to a third party. In such an
424.27 event, the license holder will be personally liable for payment. In the case of a corporation,
424.28 each controlling individual is personally and jointly liable for payment.

424.29 (d) Except for background study violations involving the failure to comply with an
424.30 order to immediately remove an individual or an order to provide continuous, direct
424.31 supervision, the commissioner shall not issue a fine under paragraph (c) relating to a
424.32 background study violation to a license holder who self-corrects a background study
424.33 violation before the commissioner discovers the violation. A license holder who has
424.34 previously exercised the provisions of this paragraph to avoid a fine for a background
424.35 study violation may not avoid a fine for a subsequent background study violation unless at

425.1 least 365 days have passed since the license holder self-corrected the earlier background
425.2 study violation.

425.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

425.4 Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 19c, is amended to
425.5 read:

425.6 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance
425.7 services provided by an individual who is qualified to provide the services according to
425.8 subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a
425.9 plan, and supervised by a qualified professional.

425.10 "Qualified professional" means a mental health professional as defined in section
425.11 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);
425.12 ~~or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker~~
425.13 ~~as defined in sections 148E.010 and 148E.055, or a qualified developmental disabilities~~
425.14 ~~specialist under section 245B.07, subdivision 4~~ designated coordinator under section
425.15 245D.081, subdivision 2. The qualified professional shall perform the duties required in
425.16 section 256B.0659.

425.17 **EFFECTIVE DATE.** This section is effective January 1, 2014.

425.18 Sec. 11. Minnesota Statutes 2012, section 256B.5011, subdivision 2, is amended to read:

425.19 Subd. 2. **Contract provisions.** (a) The service contract with each intermediate
425.20 care facility must include provisions for:

- 425.21 (1) modifying payments when significant changes occur in the needs of the
425.22 consumers;
- 425.23 (2) appropriate and necessary statistical information required by the commissioner;
- 425.24 (3) annual aggregate facility financial information; and
- 425.25 (4) additional requirements for intermediate care facilities not meeting the standards
425.26 set forth in the service contract.

425.27 (b) The commissioner of human services and the commissioner of health, in
425.28 consultation with representatives from counties, advocacy organizations, and the provider
425.29 community, shall review ~~the consolidated standards under chapter 245B and~~ the home and
425.30 community-based services standards under chapter 245D and the supervised living facility
425.31 rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota
425.32 Rules, chapter 4665, may be waived by the commissioner of health for intermediate care
425.33 facilities in order to enable facilities to implement the performance measures in their

426.1 contract and provide quality services to residents without a duplication of or increase in
426.2 regulatory requirements.

426.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

426.4 Sec. 12. Minnesota Statutes 2012, section 471.59, subdivision 1, is amended to read:

426.5 Subdivision 1. **Agreement.** Two or more governmental units, by agreement entered
426.6 into through action of their governing bodies, may jointly or cooperatively exercise
426.7 any power common to the contracting parties or any similar powers, including those
426.8 which are the same except for the territorial limits within which they may be exercised.
426.9 The agreement may provide for the exercise of such powers by one or more of the
426.10 participating governmental units on behalf of the other participating units. The term
426.11 "governmental unit" as used in this section includes every city, county, town, school
426.12 district, independent nonprofit firefighting corporation, other political subdivision of
426.13 this or another state, another state, federally recognized Indian tribe, the University
426.14 of Minnesota, the Minnesota Historical Society, nonprofit hospitals licensed under
426.15 sections 144.50 to 144.56, rehabilitation facilities and extended employment providers
426.16 that are certified by the commissioner of employment and economic development, ~~day~~
426.17 ~~training and habilitation services licensed under sections 245B.01 to 245B.08, day and~~
426.18 supported employment services licensed under chapter 245D, and any agency of the state
426.19 of Minnesota or the United States, and includes any instrumentality of a governmental
426.20 unit. For the purpose of this section, an instrumentality of a governmental unit means an
426.21 instrumentality having independent policy-making and appropriating authority.

426.22 **EFFECTIVE DATE.** This section is effective January 1, 2014.

426.23 Sec. 13. Minnesota Statutes 2012, section 626.556, subdivision 2, is amended to read:

426.24 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
426.25 given them unless the specific content indicates otherwise:

426.26 (a) "Family assessment" means a comprehensive assessment of child safety, risk
426.27 of subsequent child maltreatment, and family strengths and needs that is applied to a
426.28 child maltreatment report that does not allege substantial child endangerment. Family
426.29 assessment does not include a determination as to whether child maltreatment occurred
426.30 but does determine the need for services to address the safety of family members and the
426.31 risk of subsequent maltreatment.

426.32 (b) "Investigation" means fact gathering related to the current safety of a child
426.33 and the risk of subsequent maltreatment that determines whether child maltreatment

427.1 occurred and whether child protective services are needed. An investigation must be used
427.2 when reports involve substantial child endangerment, and for reports of maltreatment in
427.3 facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to
427.4 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and
427.5 13, and 124D.10; or in a nonlicensed personal care provider association as defined in
427.6 sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

427.7 (c) "Substantial child endangerment" means a person responsible for a child's care,
427.8 and in the case of sexual abuse includes a person who has a significant relationship to the
427.9 child as defined in section 609.341, or a person in a position of authority as defined in
427.10 section 609.341, who by act or omission commits or attempts to commit an act against a
427.11 child under their care that constitutes any of the following:

427.12 (1) egregious harm as defined in section 260C.007, subdivision 14;

427.13 (2) sexual abuse as defined in paragraph (d);

427.14 (3) abandonment under section 260C.301, subdivision 2;

427.15 (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the
427.16 child's physical or mental health, including a growth delay, which may be referred to as
427.17 failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

427.18 (5) murder in the first, second, or third degree under section 609.185, 609.19, or
427.19 609.195;

427.20 (6) manslaughter in the first or second degree under section 609.20 or 609.205;

427.21 (7) assault in the first, second, or third degree under section 609.221, 609.222, or
427.22 609.223;

427.23 (8) solicitation, inducement, and promotion of prostitution under section 609.322;

427.24 (9) criminal sexual conduct under sections 609.342 to 609.3451;

427.25 (10) solicitation of children to engage in sexual conduct under section 609.352;

427.26 (11) malicious punishment or neglect or endangerment of a child under section
427.27 609.377 or 609.378;

427.28 (12) use of a minor in sexual performance under section 617.246; or

427.29 (13) parental behavior, status, or condition which mandates that the county attorney
427.30 file a termination of parental rights petition under section 260C.301, subdivision 3,
427.31 paragraph (a).

427.32 (d) "Sexual abuse" means the subjection of a child by a person responsible for the
427.33 child's care, by a person who has a significant relationship to the child, as defined in
427.34 section 609.341, or by a person in a position of authority, as defined in section 609.341,
427.35 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual
427.36 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),

428.1 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct
428.2 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual
428.3 abuse also includes any act which involves a minor which constitutes a violation of
428.4 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes
428.5 threatened sexual abuse which includes the status of a parent or household member
428.6 who has committed a violation which requires registration as an offender under section
428.7 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section
428.8 243.166, subdivision 1b, paragraph (a) or (b).

428.9 (e) "Person responsible for the child's care" means (1) an individual functioning
428.10 within the family unit and having responsibilities for the care of the child such as a
428.11 parent, guardian, or other person having similar care responsibilities, or (2) an individual
428.12 functioning outside the family unit and having responsibilities for the care of the child
428.13 such as a teacher, school administrator, other school employees or agents, or other lawful
428.14 custodian of a child having either full-time or short-term care responsibilities including,
428.15 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
428.16 and coaching.

428.17 (f) "Neglect" means the commission or omission of any of the acts specified under
428.18 clauses (1) to (9), other than by accidental means:

428.19 (1) failure by a person responsible for a child's care to supply a child with necessary
428.20 food, clothing, shelter, health, medical, or other care required for the child's physical or
428.21 mental health when reasonably able to do so;

428.22 (2) failure to protect a child from conditions or actions that seriously endanger the
428.23 child's physical or mental health when reasonably able to do so, including a growth delay,
428.24 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
428.25 is due to parental neglect;

428.26 (3) failure to provide for necessary supervision or child care arrangements
428.27 appropriate for a child after considering factors as the child's age, mental ability, physical
428.28 condition, length of absence, or environment, when the child is unable to care for the
428.29 child's own basic needs or safety, or the basic needs or safety of another child in their care;

428.30 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
428.31 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
428.32 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

428.33 (5) nothing in this section shall be construed to mean that a child is neglected solely
428.34 because the child's parent, guardian, or other person responsible for the child's care in
428.35 good faith selects and depends upon spiritual means or prayer for treatment or care of
428.36 disease or remedial care of the child in lieu of medical care; except that a parent, guardian,

429.1 or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report
429.2 if a lack of medical care may cause serious danger to the child's health. This section does
429.3 not impose upon persons, not otherwise legally responsible for providing a child with
429.4 necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

429.5 (6) prenatal exposure to a controlled substance, as defined in section 253B.02,
429.6 subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal
429.7 symptoms in the child at birth, results of a toxicology test performed on the mother at
429.8 delivery or the child at birth, medical effects or developmental delays during the child's
429.9 first year of life that medically indicate prenatal exposure to a controlled substance, or the
429.10 presence of a fetal alcohol spectrum disorder;

429.11 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

429.12 (8) chronic and severe use of alcohol or a controlled substance by a parent or
429.13 person responsible for the care of the child that adversely affects the child's basic needs
429.14 and safety; or

429.15 (9) emotional harm from a pattern of behavior which contributes to impaired
429.16 emotional functioning of the child which may be demonstrated by a substantial and
429.17 observable effect in the child's behavior, emotional response, or cognition that is not
429.18 within the normal range for the child's age and stage of development, with due regard to
429.19 the child's culture.

429.20 (g) "Physical abuse" means any physical injury, mental injury, or threatened injury,
429.21 inflicted by a person responsible for the child's care on a child other than by accidental
429.22 means, or any physical or mental injury that cannot reasonably be explained by the child's
429.23 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
429.24 that have not been authorized under section 121A.67 or 245.825.

429.25 Abuse does not include reasonable and moderate physical discipline of a child
429.26 administered by a parent or legal guardian which does not result in an injury. Abuse does
429.27 not include the use of reasonable force by a teacher, principal, or school employee as
429.28 allowed by section 121A.582. Actions which are not reasonable and moderate include,
429.29 but are not limited to, any of the following that are done in anger or without regard to the
429.30 safety of the child:

429.31 (1) throwing, kicking, burning, biting, or cutting a child;

429.32 (2) striking a child with a closed fist;

429.33 (3) shaking a child under age three;

429.34 (4) striking or other actions which result in any nonaccidental injury to a child
429.35 under 18 months of age;

429.36 (5) unreasonable interference with a child's breathing;

430.1 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

430.2 (7) striking a child under age one on the face or head;

430.3 (8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
430.4 substances which were not prescribed for the child by a practitioner, in order to control or
430.5 punish the child; or other substances that substantially affect the child's behavior, motor
430.6 coordination, or judgment or that results in sickness or internal injury, or subjects the
430.7 child to medical procedures that would be unnecessary if the child were not exposed
430.8 to the substances;

430.9 (9) unreasonable physical confinement or restraint not permitted under section
430.10 609.379, including but not limited to tying, caging, or chaining; or

430.11 (10) in a school facility or school zone, an act by a person responsible for the child's
430.12 care that is a violation under section 121A.58.

430.13 (h) "Report" means any report received by the local welfare agency, police
430.14 department, county sheriff, or agency responsible for assessing or investigating
430.15 maltreatment pursuant to this section.

430.16 (i) "Facility" means:

430.17 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
430.18 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
430.19 144.58, 241.021, or 245A.01 to 245A.16, or chapter ~~245B~~ 245D;

430.20 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
430.21 124D.10; or

430.22 (3) a nonlicensed personal care provider organization as defined in sections 256B.04,
430.23 subdivision 16, and 256B.0625, subdivision 19a.

430.24 (j) "Operator" means an operator or agency as defined in section 245A.02.

430.25 (k) "Commissioner" means the commissioner of human services.

430.26 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
430.27 not limited to employee assistance counseling and the provision of guardian ad litem and
430.28 parenting time expeditor services.

430.29 (m) "Mental injury" means an injury to the psychological capacity or emotional
430.30 stability of a child as evidenced by an observable or substantial impairment in the child's
430.31 ability to function within a normal range of performance and behavior with due regard to
430.32 the child's culture.

430.33 (n) "Threatened injury" means a statement, overt act, condition, or status that
430.34 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
430.35 injury includes, but is not limited to, exposing a child to a person responsible for the
430.36 child's care, as defined in paragraph (e), clause (1), who has:

431.1 (1) subjected a child to, or failed to protect a child from, an overt act or condition
431.2 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
431.3 similar law of another jurisdiction;

431.4 (2) been found to be palpably unfit under section 260C.301, paragraph (b), clause
431.5 (4), or a similar law of another jurisdiction;

431.6 (3) committed an act that has resulted in an involuntary termination of parental rights
431.7 under section 260C.301, or a similar law of another jurisdiction; or

431.8 (4) committed an act that has resulted in the involuntary transfer of permanent
431.9 legal and physical custody of a child to a relative under Minnesota Statutes 2010, section
431.10 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a
431.11 similar law of another jurisdiction.

431.12 A child is the subject of a report of threatened injury when the responsible social
431.13 services agency receives birth match data under paragraph (o) from the Department of
431.14 Human Services.

431.15 (o) Upon receiving data under section 144.225, subdivision 2b, contained in a
431.16 birth record or recognition of parentage identifying a child who is subject to threatened
431.17 injury under paragraph (n), the Department of Human Services shall send the data to the
431.18 responsible social services agency. The data is known as "birth match" data. Unless the
431.19 responsible social services agency has already begun an investigation or assessment of the
431.20 report due to the birth of the child or execution of the recognition of parentage and the
431.21 parent's previous history with child protection, the agency shall accept the birth match
431.22 data as a report under this section. The agency may use either a family assessment or
431.23 investigation to determine whether the child is safe. All of the provisions of this section
431.24 apply. If the child is determined to be safe, the agency shall consult with the county
431.25 attorney to determine the appropriateness of filing a petition alleging the child is in need
431.26 of protection or services under section 260C.007, subdivision 6, clause (16), in order to
431.27 deliver needed services. If the child is determined not to be safe, the agency and the county
431.28 attorney shall take appropriate action as required under section 260C.301, subdivision 3.

431.29 (p) Persons who conduct assessments or investigations under this section shall take
431.30 into account accepted child-rearing practices of the culture in which a child participates
431.31 and accepted teacher discipline practices, which are not injurious to the child's health,
431.32 welfare, and safety.

431.33 (q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected
431.34 occurrence or event which:

431.35 (1) is not likely to occur and could not have been prevented by exercise of due
431.36 care; and

432.1 (2) if occurring while a child is receiving services from a facility, happens when the
432.2 facility and the employee or person providing services in the facility are in compliance
432.3 with the laws and rules relevant to the occurrence or event.

432.4 (r) "Nonmaltreatment mistake" means:

432.5 (1) at the time of the incident, the individual was performing duties identified in the
432.6 center's child care program plan required under Minnesota Rules, part 9503.0045;

432.7 (2) the individual has not been determined responsible for a similar incident that
432.8 resulted in a finding of maltreatment for at least seven years;

432.9 (3) the individual has not been determined to have committed a similar
432.10 nonmaltreatment mistake under this paragraph for at least four years;

432.11 (4) any injury to a child resulting from the incident, if treated, is treated only with
432.12 remedies that are available over the counter, whether ordered by a medical professional or
432.13 not; and

432.14 (5) except for the period when the incident occurred, the facility and the individual
432.15 providing services were both in compliance with all licensing requirements relevant to the
432.16 incident.

432.17 This definition only applies to child care centers licensed under Minnesota
432.18 Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of
432.19 substantiated maltreatment by the individual, the commissioner of human services shall
432.20 determine that a nonmaltreatment mistake was made by the individual.

432.21 **EFFECTIVE DATE.** This section is effective January 1, 2014.

432.22 Sec. 14. Minnesota Statutes 2012, section 626.556, subdivision 3, is amended to read:

432.23 Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason
432.24 to believe a child is being neglected or physically or sexually abused, as defined in
432.25 subdivision 2, or has been neglected or physically or sexually abused within the preceding
432.26 three years, shall immediately report the information to the local welfare agency, agency
432.27 responsible for assessing or investigating the report, police department, or the county
432.28 sheriff if the person is:

432.29 (1) a professional or professional's delegate who is engaged in the practice of
432.30 the healing arts, social services, hospital administration, psychological or psychiatric
432.31 treatment, child care, education, correctional supervision, probation and correctional
432.32 services, or law enforcement; or

432.33 (2) employed as a member of the clergy and received the information while
432.34 engaged in ministerial duties, provided that a member of the clergy is not required by

433.1 this subdivision to report information that is otherwise privileged under section 595.02,
433.2 subdivision 1, paragraph (c).

433.3 The police department or the county sheriff, upon receiving a report, shall
433.4 immediately notify the local welfare agency or agency responsible for assessing or
433.5 investigating the report, orally and in writing. The local welfare agency, or agency
433.6 responsible for assessing or investigating the report, upon receiving a report, shall
433.7 immediately notify the local police department or the county sheriff orally and in writing.
433.8 The county sheriff and the head of every local welfare agency, agency responsible
433.9 for assessing or investigating reports, and police department shall each designate a
433.10 person within their agency, department, or office who is responsible for ensuring that
433.11 the notification duties of this paragraph and paragraph (b) are carried out. Nothing in
433.12 this subdivision shall be construed to require more than one report from any institution,
433.13 facility, school, or agency.

433.14 (b) Any person may voluntarily report to the local welfare agency, agency responsible
433.15 for assessing or investigating the report, police department, or the county sheriff if the
433.16 person knows, has reason to believe, or suspects a child is being or has been neglected or
433.17 subjected to physical or sexual abuse. The police department or the county sheriff, upon
433.18 receiving a report, shall immediately notify the local welfare agency or agency responsible
433.19 for assessing or investigating the report, orally and in writing. The local welfare agency or
433.20 agency responsible for assessing or investigating the report, upon receiving a report, shall
433.21 immediately notify the local police department or the county sheriff orally and in writing.

433.22 (c) A person mandated to report physical or sexual child abuse or neglect occurring
433.23 within a licensed facility shall report the information to the agency responsible for
433.24 licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or
433.25 chapter ~~245B~~ 245D; or a nonlicensed personal care provider organization as defined in
433.26 sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections
433.27 agency receiving a report may request the local welfare agency to provide assistance
433.28 pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees
433.29 perform work within a school facility, upon receiving a complaint of alleged maltreatment,
433.30 shall provide information about the circumstances of the alleged maltreatment to the
433.31 commissioner of education. Section 13.03, subdivision 4, applies to data received by the
433.32 commissioner of education from a licensing entity.

433.33 (d) Any person mandated to report shall receive a summary of the disposition of
433.34 any report made by that reporter, including whether the case has been opened for child
433.35 protection or other services, or if a referral has been made to a community organization,
433.36 unless release would be detrimental to the best interests of the child. Any person who is

434.1 not mandated to report shall, upon request to the local welfare agency, receive a concise
434.2 summary of the disposition of any report made by that reporter, unless release would be
434.3 detrimental to the best interests of the child.

434.4 (e) For purposes of this section, "immediately" means as soon as possible but in
434.5 no event longer than 24 hours.

434.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

434.7 Sec. 15. Minnesota Statutes 2012, section 626.556, subdivision 10d, is amended to read:

434.8 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is
434.9 received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while
434.10 in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
434.11 sanitarium, or other facility or institution required to be licensed according to sections
434.12 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter ~~245B~~ 245D, or a school as
434.13 defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed
434.14 personal care provider organization as defined in section 256B.04, subdivision 16, and
434.15 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing
434.16 or investigating the report or local welfare agency investigating the report shall provide
434.17 the following information to the parent, guardian, or legal custodian of a child alleged to
434.18 have been neglected, physically abused, sexually abused, or the victim of maltreatment
434.19 of a child in the facility: the name of the facility; the fact that a report alleging neglect,
434.20 physical abuse, sexual abuse, or maltreatment of a child in the facility has been received;
434.21 the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child
434.22 in the facility; that the agency is conducting an assessment or investigation; any protective
434.23 or corrective measures being taken pending the outcome of the investigation; and that a
434.24 written memorandum will be provided when the investigation is completed.

434.25 (b) The commissioner of the agency responsible for assessing or investigating the
434.26 report or local welfare agency may also provide the information in paragraph (a) to the
434.27 parent, guardian, or legal custodian of any other child in the facility if the investigative
434.28 agency knows or has reason to believe the alleged neglect, physical abuse, sexual
434.29 abuse, or maltreatment of a child in the facility has occurred. In determining whether
434.30 to exercise this authority, the commissioner of the agency responsible for assessing
434.31 or investigating the report or local welfare agency shall consider the seriousness of the
434.32 alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the
434.33 number of children allegedly neglected, physically abused, sexually abused, or victims of
434.34 maltreatment of a child in the facility; the number of alleged perpetrators; and the length
434.35 of the investigation. The facility shall be notified whenever this discretion is exercised.

435.1 (c) When the commissioner of the agency responsible for assessing or investigating
 435.2 the report or local welfare agency has completed its investigation, every parent, guardian,
 435.3 or legal custodian previously notified of the investigation by the commissioner or
 435.4 local welfare agency shall be provided with the following information in a written
 435.5 memorandum: the name of the facility investigated; the nature of the alleged neglect,
 435.6 physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's
 435.7 name; a summary of the investigation findings; a statement whether maltreatment was
 435.8 found; and the protective or corrective measures that are being or will be taken. The
 435.9 memorandum shall be written in a manner that protects the identity of the reporter and
 435.10 the child and shall not contain the name, or to the extent possible, reveal the identity of
 435.11 the alleged perpetrator or of those interviewed during the investigation. If maltreatment
 435.12 is determined to exist, the commissioner or local welfare agency shall also provide the
 435.13 written memorandum to the parent, guardian, or legal custodian of each child in the facility
 435.14 who had contact with the individual responsible for the maltreatment. When the facility is
 435.15 the responsible party for maltreatment, the commissioner or local welfare agency shall also
 435.16 provide the written memorandum to the parent, guardian, or legal custodian of each child
 435.17 who received services in the population of the facility where the maltreatment occurred.
 435.18 This notification must be provided to the parent, guardian, or legal custodian of each child
 435.19 receiving services from the time the maltreatment occurred until either the individual
 435.20 responsible for maltreatment is no longer in contact with a child or children in the facility
 435.21 or the conclusion of the investigation. In the case of maltreatment within a school facility,
 435.22 as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10, the commissioner
 435.23 of education need not provide notification to parents, guardians, or legal custodians of
 435.24 each child in the facility, but shall, within ten days after the investigation is completed,
 435.25 provide written notification to the parent, guardian, or legal custodian of any student
 435.26 alleged to have been maltreated. The commissioner of education may notify the parent,
 435.27 guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

435.28 **EFFECTIVE DATE.** This section is effective January 1, 2014.

435.29 Sec. 16. **REPEALER.**

435.30 Minnesota Statutes 2012, section 256B.49, subdivision 16a, is repealed effective
 435.31 January 1, 2014.

435.32 **ARTICLE 10**

435.33 **HEALTH-RELATED LICENSING BOARDS**

435.34 Section 1. Minnesota Statutes 2012, section 148B.17, subdivision 2, is amended to read:

436.1 Subd. 2. **Licensure and application fees.** Nonrefundable licensure and application
436.2 fees ~~charged~~ established by the board are as follows shall not exceed the following amounts:

436.3 (1) application fee for national examination is ~~\$220~~ \$110;

436.4 (2) application fee for Licensed Marriage and Family Therapist (LMFT) state
436.5 examination is \$110;

436.6 (3) initial LMFT license fee is prorated, but cannot exceed \$125;

436.7 (4) annual renewal fee for LMFT license is \$125;

436.8 (5) late fee for ~~initial Licensed Associate Marriage and Family Therapist LAMFT~~
436.9 LMFT license renewal is \$50;

436.10 (6) application fee for LMFT licensure by reciprocity is ~~\$340~~ \$220;

436.11 (7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT)
436.12 license is \$75;

436.13 (8) annual renewal fee for LAMFT license is \$75;

436.14 (9) late fee for LAMFT renewal is ~~\$50~~ \$25;

436.15 (10) fee for reinstatement of license is \$150; and

436.16 (11) fee for emeritus status is \$125.

436.17 Sec. 2. Minnesota Statutes 2012, section 151.19, subdivision 1, is amended to read:

436.18 Subdivision 1. **Pharmacy ~~registration~~ licensure requirements.** ~~The board shall~~
436.19 ~~require and provide for the annual registration of every pharmacy now or hereafter doing~~
436.20 ~~business within this state. Upon the payment of any applicable fee specified in section~~
436.21 ~~151.065, the board shall issue a registration certificate in such form as it may prescribe to~~
436.22 ~~such persons as may be qualified by law to conduct a pharmacy. Such certificate shall~~
436.23 ~~be displayed in a conspicuous place in the pharmacy for which it is issued and expire on~~
436.24 ~~the 30th day of June following the date of issue. It shall be unlawful for any person to~~
436.25 ~~conduct a pharmacy unless such certificate has been issued to the person by the board. (a)~~
436.26 No person shall operate a pharmacy without first obtaining a license from the board and
436.27 paying any applicable fee specified in section 151.065. The license shall be displayed in a
436.28 conspicuous place in the pharmacy for which it is issued and expires on June 30 following
436.29 the date of issue. It is unlawful for any person to operate a pharmacy unless the license
436.30 has been issued to the person by the board.

436.31 (b) Application for a pharmacy license under this section shall be made in a manner
436.32 specified by the board.

436.33 (c) No license shall be issued or renewed for a pharmacy located within the state
436.34 unless the applicant agrees to operate the pharmacy in a manner prescribed by federal and
436.35 state law and according to rules adopted by the board. No license shall be issued for a

437.1 pharmacy located outside of the state unless the applicant agrees to operate the pharmacy
437.2 in a manner prescribed by federal law and, when dispensing medications for residents of
437.3 this state, the laws of this state, and Minnesota Rules.

437.4 (d) No license shall be issued or renewed for a pharmacy that is required to be
437.5 licensed or registered by the state in which it is physically located unless the applicant
437.6 supplies the board with proof of such licensure or registration.

437.7 (e) The board shall require a separate license for each pharmacy located within
437.8 the state and for each pharmacy located outside of the state at which any portion of the
437.9 dispensing process occurs for drugs dispensed to residents of this state.

437.10 (f) The board shall not issue an initial or renewed license for a pharmacy unless the
437.11 pharmacy passes an inspection conducted by an authorized representative of the board. In
437.12 the case of a pharmacy located outside of the state, the board may require the applicant to
437.13 pay the cost of the inspection, in addition to the license fee in section 151.065, unless the
437.14 applicant furnishes the board with a report, issued by the appropriate regulatory agency of
437.15 the state in which the facility is located, of an inspection that has occurred within the 24
437.16 months immediately preceding receipt of the license application by the board. The board
437.17 may deny licensure unless the applicant submits documentation satisfactory to the board
437.18 that any deficiencies noted in an inspection report have been corrected.

437.19 (g) The board shall not issue an initial or renewed license for a pharmacy located
437.20 outside of the state unless the applicant discloses and certifies:

437.21 (1) the location, names, and titles of all principal corporate officers and all
437.22 pharmacists who are involved in dispensing drugs to residents of this state;

437.23 (2) that it maintains its records of drugs dispensed to residents of this state so that the
437.24 records are readily retrievable from the records of other drugs dispensed;

437.25 (3) that it agrees to cooperate with, and provide information to, the board concerning
437.26 matters related to dispensing drugs to residents of this state;

437.27 (4) that, during its regular hours of operation, but no less than six days per week, for
437.28 a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate
437.29 communication between patients in this state and a pharmacist at the pharmacy who has
437.30 access to the patients' records; the toll-free number must be disclosed on the label affixed
437.31 to each container of drugs dispensed to residents of this state; and

437.32 (5) that, upon request of a resident of a long-term care facility located in this
437.33 state, the resident's authorized representative, or a contract pharmacy or licensed health
437.34 care facility acting on behalf of the resident, the pharmacy will dispense medications
437.35 prescribed for the resident in unit-dose packaging or, alternatively, comply with section
437.36 151.415, subdivision 5.

438.1 Sec. 3. Minnesota Statutes 2012, section 151.19, subdivision 3, is amended to read:

438.2 Subd. 3. **Sale of federally restricted medical gases.** ~~The board shall require and~~
438.3 ~~provide for the annual registration of every person or establishment not licensed as a~~
438.4 ~~pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted~~
438.5 ~~medical gases. Upon the payment of any applicable fee specified in section 151.065, the~~
438.6 ~~board shall issue a registration certificate in such form as it may prescribe to those persons~~
438.7 ~~or places that may be qualified to sell or distribute federally restricted medical gases. The~~
438.8 ~~certificate shall be displayed in a conspicuous place in the business for which it is issued~~
438.9 ~~and expire on the date set by the board. It is unlawful for a person to sell or distribute~~
438.10 ~~federally restricted medical gases unless a certificate has been issued to that person by the~~
438.11 ~~board.~~ (a) A person or establishment not licensed as a pharmacy or a practitioner shall not
438.12 engage in the retail sale or distribution of federally restricted medical gases without first
438.13 obtaining a registration from the board and paying the applicable fee specified in section
438.14 151.065. The registration shall be displayed in a conspicuous place in the business for
438.15 which it is issued and expires on the date set by the board. It is unlawful for a person to
438.16 sell or distribute federally restricted medical gases unless a certificate has been issued to
438.17 that person by the board.

438.18 (b) Application for a medical gas distributor registration under this section shall be
438.19 made in a manner specified by the board.

438.20 (c) No registration shall be issued or renewed for a medical gas distributor located
438.21 within the state unless the applicant agrees to operate in a manner prescribed by federal
438.22 and state law and according to the rules adopted by the board. No license shall be issued
438.23 for a medical gas distributor located outside of the state unless the applicant agrees to
438.24 operate in a manner prescribed by federal law and, when distributing medical gases for
438.25 residents of this state, the laws of this state and Minnesota Rules.

438.26 (d) No registration shall be issued or renewed for a medical gas distributor that is
438.27 required to be licensed or registered by the state in which it is physically located unless the
438.28 applicant supplies the board with proof of the licensure or registration. The board may, by
438.29 rule, establish standards for the registration of a medical gas distributor that is not required
438.30 to be licensed or registered by the state in which it is physically located.

438.31 (e) The board shall require a separate registration for each medical gas distributor
438.32 located within the state and for each facility located outside of the state from which
438.33 medical gases are distributed to residents of this state.

438.34 (f) The board shall not issue an initial or renewed registration for a medical gas
438.35 distributor unless the medical gas distributor passes an inspection conducted by an
438.36 authorized representative of the board. In the case of a medical gas distributor located

439.1 outside of the state, the board may require the applicant to pay the cost of the inspection,
439.2 in addition to the license fee in section 151.065, unless the applicant furnishes the board
439.3 with a report, issued by the appropriate regulatory agency of the state in which the facility
439.4 is located, of an inspection that has occurred within the 24 months immediately preceding
439.5 receipt of the license application by the board. The board may deny licensure unless the
439.6 applicant submits documentation satisfactory to the board that any deficiencies noted in
439.7 an inspection report have been corrected.

439.8 Sec. 4. **[151.252] LICENSING OF DRUG MANUFACTURERS; FEES;**
439.9 **PROHIBITIONS.**

439.10 Subdivision 1. Requirements. (a) No person shall act as a drug manufacturer
439.11 without first obtaining a license from the board and paying any applicable fee specified
439.12 in section 151.065.

439.13 (b) Application for a drug manufacturer license under this section shall be made in a
439.14 manner specified by the board.

439.15 (c) No license shall be issued or renewed for a drug manufacturer unless the
439.16 applicant agrees to operate in a manner prescribed by federal and state law and according
439.17 to Minnesota Rules.

439.18 (d) No license shall be issued or renewed for a drug manufacturer that is required
439.19 to be registered pursuant to United State Code, title 21, section 360, unless the applicant
439.20 supplies the board with proof of registration. The board may establish by rule the
439.21 standards for licensure of drug manufacturers that are not required to be registered under
439.22 United States Code, title 21, section 360.

439.23 (e) No license shall be issued or renewed for a drug manufacturer that is required to
439.24 be licensed or registered by the state in which it is physically located unless the applicant
439.25 supplies the board with proof of licensure or registration. The board may establish, by
439.26 rule, standards for the licensure of a drug manufacturer that is not required to be licensed
439.27 or registered by the state in which it is physically located.

439.28 (f) The board shall require a separate license for each facility located within the state
439.29 at which drug manufacturing occurs and for each facility located outside of the state at
439.30 which drugs that are shipped into the state are manufactured.

439.31 (g) The board shall not issue an initial or renewed license for a drug manufacturing
439.32 facility unless the facility passes an inspection conducted by an authorized representative
439.33 of the board. In the case of a drug manufacturing facility located outside of the state, the
439.34 board may require the applicant to pay the cost of the inspection, in addition to the license
439.35 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the

440.1 appropriate regulatory agency of the state in which the facility is located or by the United
440.2 States Food and Drug Administration, of an inspection that has occurred within the 24
440.3 months immediately preceding receipt of the license application by the board. The board
440.4 may deny licensure unless the applicant submits documentation satisfactory to the board
440.5 that any deficiencies noted in an inspection report have been corrected.

440.6 Subd. 2. **Prohibition.** It is unlawful for any person engaged in drug manufacturing
440.7 to sell legend drugs to anyone located in this state except as provided in this chapter.

440.8 Subd. 3. **Payment to practitioner; reporting.** Unless prohibited by United States
440.9 Code, title 42, section 1320a-7h, a drug manufacturer shall file with the board an annual
440.10 report, in a form and on the date prescribed by the board, identifying all payments,
440.11 honoraria, reimbursement, or other compensation authorized under section 151.461,
440.12 clauses (4) and (5), paid to practitioners in Minnesota during the preceding calendar year.
440.13 The report shall identify the nature and value of any payments totaling \$100 or more to a
440.14 particular practitioner during the year, and shall identify the practitioner. Reports filed
440.15 under this subdivision are public data.

440.16 Sec. 5. Minnesota Statutes 2012, section 151.37, subdivision 4, is amended to read:

440.17 Subd. 4. **Research.** (a) Any qualified person may use legend drugs in the course
440.18 of a bona fide research project, but cannot administer or dispense such drugs to human
440.19 beings unless such drugs are prescribed, dispensed, and administered by a person lawfully
440.20 authorized to do so.

440.21 (b) Drugs may be dispensed or distributed by a pharmacy licensed by the board for
440.22 use by, or administration to, patients enrolled in a bona fide research study that is being
440.23 conducted pursuant to either an investigational new drug application approved by the
440.24 United States Food and Drug Administration or that has been approved by an institutional
440.25 review board. For the purposes of this subdivision only:

440.26 (1) a prescription drug order is not required for a pharmacy to dispense a research
440.27 drug, unless the study protocol requires the pharmacy to receive such an order;

440.28 (2) notwithstanding the prescription labeling requirements found in this chapter or
440.29 the rules promulgated by the board, a research drug may be labeled as required by the
440.30 study protocol; and

440.31 (3) dispensing and distribution of research drugs by pharmacies shall not be
440.32 considered compounding, manufacturing, or wholesaling under this chapter.

440.33 (c) An entity that is under contract to a federal agency for the purpose of distributing
440.34 drugs for bona fide research studies is exempt from the drug wholesaler licensing
440.35 requirements of this chapter. Any other entity is exempt from the drug wholesaler

441.1 licensing requirements of this chapter if the board finds that the entity is licensed or
441.2 registered according to the laws of the state in which it is physically located and it is
441.3 distributing drugs for use by, or administration to, patients enrolled in a bona fide research
441.4 study that is being conducted pursuant to either an investigational new drug application
441.5 approved by the United States Food and Drug Administration or that has been approved
441.6 by an institutional review board.

441.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

441.8 Sec. 6. Minnesota Statutes 2012, section 151.47, subdivision 1, is amended to read:

441.9 Subdivision 1. **Requirements.** (a) All wholesale drug distributors are subject to the
441.10 requirements ~~in paragraphs (a) to (f)~~ of this subdivision.

441.11 ~~(a)~~ (b) No person or distribution outlet shall act as a wholesale drug distributor
441.12 without first obtaining a license from the board and paying any applicable fee specified
441.13 in section 151.065.

441.14 (c) Application for a wholesale drug distributor license under this section shall be
441.15 made in a manner specified by the board.

441.16 ~~(b)~~ (d) No license shall be issued or renewed for a wholesale drug distributor to
441.17 operate unless the applicant agrees to operate in a manner prescribed by federal and state
441.18 law and according to the rules adopted by the board.

441.19 ~~(e) The board may require a separate license for each facility directly or indirectly~~
441.20 ~~owned or operated by the same business entity within the state, or for a parent entity~~
441.21 ~~with divisions, subsidiaries, or affiliate companies within the state, when operations~~
441.22 ~~are conducted at more than one location and joint ownership and control exists among~~
441.23 ~~all the entities.~~

441.24 (e) No license may be issued or renewed for a drug wholesale distributor that is
441.25 required to be licensed or registered by the state in which it is physically located unless
441.26 the applicant supplies the board with proof of licensure or registration. The board may
441.27 establish, by rule, standards for the licensure of a drug wholesale distributor that is not
441.28 required to be licensed or registered by the state in which it is physically located.

441.29 (f) The board shall require a separate license for each drug wholesale distributor
441.30 facility located within the state and for each drug wholesale distributor facility located
441.31 outside of the state from which drugs are shipped into the state or to which drugs are
441.32 reverse distributed.

441.33 (g) The board shall not issue an initial or renewed license for a drug wholesale
441.34 distributor facility unless the facility passes an inspection conducted by an authorized
441.35 representative of the board, or is accredited by an accreditation program approved by the

442.1 board. In the case of a drug wholesale distributor facility located outside of the state, the
442.2 board may require the applicant to pay the cost of the inspection, in addition to the license
442.3 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the
442.4 appropriate regulatory agency of the state in which the facility is located, of an inspection
442.5 that has occurred within the 24 months immediately preceding receipt of the license
442.6 application by the board, or furnishes the board with proof of current accreditation. The
442.7 board may deny licensure unless the applicant submits documentation satisfactory to the
442.8 board that any deficiencies noted in an inspection report have been corrected.

442.9 (d) (h) As a condition for receiving and retaining a wholesale drug distributor license
442.10 issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has
442.11 and will continuously maintain:

442.12 (1) adequate storage conditions and facilities;

442.13 (2) minimum liability and other insurance as may be required under any applicable
442.14 federal or state law;

442.15 (3) a viable security system that includes an after hours central alarm, or comparable
442.16 entry detection capability; restricted access to the premises; comprehensive employment
442.17 applicant screening; and safeguards against all forms of employee theft;

442.18 (4) a system of records describing all wholesale drug distributor activities set forth
442.19 in section 151.44 for at least the most recent two-year period, which shall be reasonably
442.20 accessible as defined by board regulations in any inspection authorized by the board;

442.21 (5) principals and persons, including officers, directors, primary shareholders,
442.22 and key management executives, who must at all times demonstrate and maintain their
442.23 capability of conducting business in conformity with sound financial practices as well
442.24 as state and federal law;

442.25 (6) complete, updated information, to be provided to the board as a condition for
442.26 obtaining and retaining a license, about each wholesale drug distributor to be licensed,
442.27 including all pertinent corporate licensee information, if applicable, or other ownership,
442.28 principal, key personnel, and facilities information found to be necessary by the board;

442.29 (7) written policies and procedures that assure reasonable wholesale drug distributor
442.30 preparation for, protection against, and handling of any facility security or operation
442.31 problems, including, but not limited to, those caused by natural disaster or government
442.32 emergency, inventory inaccuracies or product shipping and receiving, outdated product
442.33 or other unauthorized product control, appropriate disposition of returned goods, and
442.34 product recalls;

442.35 (8) sufficient inspection procedures for all incoming and outgoing product
442.36 shipments; and

443.1 (9) operations in compliance with all federal requirements applicable to wholesale
443.2 drug distribution.

443.3 (e) (i) An agent or employee of any licensed wholesale drug distributor need not
443.4 seek licensure under this section.

443.5 (f) ~~A wholesale drug distributor shall file with the board an annual report, in a~~
443.6 ~~form and on the date prescribed by the board, identifying all payments, honoraria,~~
443.7 ~~reimbursement or other compensation authorized under section 151.461, clauses (3) to~~
443.8 ~~(5), paid to practitioners in Minnesota during the preceding calendar year. The report~~
443.9 ~~shall identify the nature and value of any payments totaling \$100 or more, to a particular~~
443.10 ~~practitioner during the year, and shall identify the practitioner. Reports filed under this~~
443.11 ~~provision are public data.~~

443.12 Sec. 7. Minnesota Statutes 2012, section 151.47, is amended by adding a subdivision
443.13 to read:

443.14 Subd. 3. **Prohibition.** It is unlawful for any person engaged in wholesale drug
443.15 distribution to sell drugs to a person located within the state or to receive drugs in reverse
443.16 distribution from a person located within the state except as provided in this chapter.

443.17 Sec. 8. Minnesota Statutes 2012, section 151.49, is amended to read:

443.18 **151.49 LICENSE RENEWAL APPLICATION PROCEDURES.**

443.19 Application blanks or notices for renewal of a license required by sections 151.42
443.20 to 151.51 shall be mailed or otherwise provided to each licensee on or before the first
443.21 day of the month prior to the month in which the license expires and, if application for
443.22 renewal of the license with the required fee and supporting documents is not made before
443.23 the expiration date, the existing license or renewal shall lapse and become null and void
443.24 upon the date of expiration.

443.25 Sec. 9. **[214.075] HEALTH-RELATED LICENSING BOARDS; CRIMINAL**
443.26 **BACKGROUND CHECKS.**

443.27 Subdivision 1. **Applications.** (a) By January 1, 2018, each health-related licensing
443.28 board, as defined in section 214.01, subdivision 2, shall require applicants for initial
443.29 licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse
443.30 in licensure, as defined by the individual health-related licensing boards, to submit to
443.31 a criminal history records check of state data completed by the Bureau of Criminal
443.32 Apprehension (BCA) and a national criminal history records check, including a search of
443.33 the records of the Federal Bureau of Investigation (FBI).

444.1 (b) An applicant must complete a criminal background check if more than one year
444.2 has elapsed since the applicant last submitted a background check to the board.

444.3 Subd. 2. **Investigations.** If a health-related licensing board has reasonable cause
444.4 to believe a licensee has been charged with or convicted of a crime in this or any other
444.5 jurisdiction, the health-related licensing board may require the licensee to submit to a
444.6 criminal history records check of state data completed by the BCA and a national criminal
444.7 history records check, including a search of the records of the FBI.

444.8 Subd. 3. **Consent form; fees; fingerprints.** (a) In order to effectuate the federal
444.9 and state level, fingerprint-based criminal background check, the applicant or licensee
444.10 must submit a completed criminal history records check consent form and a full set of
444.11 fingerprints to the respective health-related licensing board or a designee in the manner
444.12 and form specified by the board.

444.13 (b) The applicant or licensee is responsible for all fees associated with preparation of
444.14 the fingerprints, the criminal records check consent form, and the criminal background
444.15 check. The fees for the criminal records background check shall be set by the BCA and
444.16 the FBI and are not refundable. The fees shall be submitted to the respective health-related
444.17 licensing board by the applicant or licensee as prescribed by the respective board.

444.18 (c) All fees received by the health-related licensing boards under this subdivision
444.19 shall be deposited in a dedicated account in the special revenue fund and are appropriated
444.20 to the Board of Nursing Home Administrators for the administrative services unit to pay
444.21 for the criminal background checks conducted by the Bureau of Criminal Apprehension
444.22 and Federal Bureau of Investigation.

444.23 Subd. 4. **Refusal to consent.** (a) The health-related licensing boards shall not issue
444.24 a license to any applicant who refuses to consent to a criminal background check or fails
444.25 to submit fingerprints within 90 days after submission of an application for licensure. Any
444.26 fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent
444.27 to the criminal background check or fails to submit the required fingerprints.

444.28 (b) The failure of a licensee to submit to a criminal background check as provided in
444.29 subdivision 3 is grounds for disciplinary action by the respective health licensing board.

444.30 Subd. 5. **Submission of fingerprints to the Bureau of Criminal Apprehension.**
444.31 The health-related licensing board or designee shall submit applicant or licensee
444.32 fingerprints to the BCA. The BCA shall perform a check for state criminal justice
444.33 information and shall forward the applicant's or licensee's fingerprints to the FBI to
444.34 perform a check for national criminal justice information regarding the applicant or
444.35 licensee. The BCA shall report to the board the results of the state and national criminal
444.36 justice information checks.

445.1 Subd. 6. **Alternatives to fingerprint-based criminal background checks.** The
445.2 health-related licensing board may require an alternative method of criminal history
445.3 checks for an applicant or licensee who has submitted at least three sets of fingerprints in
445.4 accordance with this section that have been unreadable by the BCA or the FBI.

445.5 Subd. 7. **Opportunity to challenge accuracy of report.** Prior to taking disciplinary
445.6 action against an applicant or a licensee based on a criminal conviction, the health-related
445.7 licensing board shall provide the applicant or the licensee an opportunity to complete or
445.8 challenge the accuracy of the criminal history information reported to the board. The
445.9 applicant or licensee shall have 30 calendar days following notice from the board of
445.10 the intent to deny licensure or to take disciplinary action to request an opportunity to
445.11 correct or complete the record prior to the board taking disciplinary action based on the
445.12 information reported to the board. The board shall provide the applicant up to 180 days to
445.13 challenge the accuracy or completeness of the report with the agency responsible for the
445.14 record. This subdivision does not affect the right of the subject of the data to contest the
445.15 accuracy or completeness under section 13.04, subdivision 4.

445.16 Subd. 8. **Instructions to the board; plans.** The health-related licensing boards, in
445.17 collaboration with the commissioner of human services and the BCA, shall establish a
445.18 plan for completing criminal background checks of all licensees who were licensed before
445.19 the effective date requirement under subdivision 1. The plan must seek to minimize
445.20 duplication of requirements for background checks of licensed health professionals. The
445.21 plan for background checks of current licensees shall be developed no later than January
445.22 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI
445.23 in which any new crimes that an applicant or licensee commits after an initial background
445.24 check are flagged in the BCA's or FBI's database and reported back to the board. The plan
445.25 shall include recommendations for any necessary statutory changes.

445.26 Sec. 10. Minnesota Statutes 2012, section 214.12, is amended by adding a subdivision
445.27 to read:

445.28 Subd. 4. **Parental depression.** The health-related licensing boards that regulate
445.29 professions that serve caregivers at risk of depression, or their children, including
445.30 behavioral health and therapy, chiropractic, marriage and family therapy, medical practice,
445.31 nursing, psychology, and social work, shall provide educational materials to licensees on
445.32 the subject of parental depression and its potential effects on children if unaddressed,
445.33 including how to:

445.34 (1) screen mothers for depression;

445.35 (2) identify children who are affected by their mother's depression; and

446.1 (3) provide treatment or referral information on needed services.

446.2 Sec. 11. Minnesota Statutes 2012, section 214.40, subdivision 1, is amended to read:

446.3 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this
446.4 section.

446.5 (b) "Administrative services unit" means the administrative services unit for the
446.6 health-related licensing boards.

446.7 (c) "Charitable organization" means a charitable organization within the meaning of
446.8 section 501(c)(3) of the Internal Revenue Code that has as a purpose the sponsorship or
446.9 support of programs designed to improve the quality, awareness, and availability of health
446.10 care services and that serves as a funding mechanism for providing those services.

446.11 (d) "Health care facility or organization" means a health care facility licensed under
446.12 chapter 144 or 144A, or a charitable organization.

446.13 (e) "Health care provider" means a physician licensed under chapter 147, physician
446.14 assistant ~~registered~~ licensed and practicing under chapter 147A, nurse licensed and
446.15 registered to practice under chapter 148, ~~or dentist or dental hygienist, or dental therapist~~
446.16 licensed under chapter 150A, or an advanced dental therapist licensed and certified under
446.17 chapter 150A.

446.18 (f) "Health care services" means health promotion, health monitoring, health
446.19 education, diagnosis, treatment, minor surgical procedures, the administration of local
446.20 anesthesia for the stitching of wounds, and primary dental services, including preventive,
446.21 diagnostic, restorative, and emergency treatment. Health care services do not include the
446.22 administration of general anesthesia or surgical procedures other than minor surgical
446.23 procedures.

446.24 (g) "Medical professional liability insurance" means medical malpractice insurance
446.25 as defined in section 62F.03.

446.26 **EFFECTIVE DATE.** This section is effective the day following final enactment.

446.27 Sec. 12. **INCLUSION OF OTHER HEALTH-RELATED OCCUPATIONS TO**
446.28 **CRIMINAL BACKGROUND CHECKS.**

446.29 (a) If the Department of Health is not reviewed by the Sunset Advisory Commission
446.30 according to the schedule in Minnesota Statutes, section 3D.21, the commissioner
446.31 of health, as the regulator for occupational therapy practitioners, speech-language
446.32 pathologists, audiologists, and hearing instrument dispensers, shall require applicants
446.33 for licensure or renewal to submit to a criminal history records check as required under

447.1 Minnesota Statutes, section 214.075, for other health-related licensed occupations
447.2 regulated by the health-related licensing boards.

447.3 (b) Any statutory changes necessary to include the commissioner of health to
447.4 Minnesota Statutes, section 214.075, shall be included in the plan required in Minnesota
447.5 Statutes, section 214.075, subdivision 8.

447.6 Sec. 13. **REPEALER.**

447.7 Minnesota Statutes 2012, sections 151.19, subdivision 2; 151.25; 151.45; 151.47,
447.8 subdivision 2; and 151.48, are repealed.

447.9 **ARTICLE 11**

447.10 **HOME CARE PROVIDERS**

447.11 Section 1. Minnesota Statutes 2012, section 13.381, subdivision 2, is amended to read:

447.12 Subd. 2. **Health occupations data.** (a) **Health-related licensees and registrants.**

447.13 The collection, analysis, reporting, and use of data on individuals licensed or registered by
447.14 the commissioner of health or health-related licensing boards are governed by sections
447.15 144.051, ~~subdivision 2~~ subdivisions 2 to 6, and 144.052.

447.16 (b) **Health services personnel.** Data collected by the commissioner of health for the
447.17 database on health services personnel are classified under section 144.1485.

447.18 Sec. 2. Minnesota Statutes 2012, section 13.381, subdivision 10, is amended to read:

447.19 Subd. 10. **Home care and hospice provider.** Data regarding a home care provider
447.20 under sections 144A.43 to 144A.47 are governed by section 144A.45. Data regarding
447.21 home care provider background studies are governed by section 144A.476, subdivision 1.
447.22 Data regarding a hospice provider under sections 144A.75 to 144A.755 are governed by
447.23 sections 144A.752 and 144A.754.

447.24 Sec. 3. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
447.25 to read:

447.26 Subd. 3. **Data classification; private data.** For providers regulated pursuant to
447.27 sections 144A.43 to 144A.482, the following data collected, created, or maintained by
447.28 the commissioner are classified as private data on individuals as defined in section 13.02,
447.29 subdivision 12:

447.30 (1) data submitted by or on behalf of applicants for licenses prior to issuance of
447.31 the license;

448.1 (2) the identity of complainants who have made reports concerning licensees or
448.2 applicants unless the complainant consents to the disclosure;

448.3 (3) the identity of individuals who provide information as part of surveys and
448.4 investigations;

448.5 (4) Social Security numbers; and

448.6 (5) health record data.

448.7 Sec. 4. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
448.8 to read:

448.9 Subd. 4. **Data classification; public data.** For providers regulated pursuant to
448.10 sections 144A.43 to 144A.482, the following data collected, created, or maintained by the
448.11 commissioner are classified as public data as defined in section 13.02, subdivision 15:

448.12 (1) all application data on licensees, license numbers, license status;

448.13 (2) licensing information about licenses previously held under this chapter;

448.14 (3) correction orders, including information about compliance with the order and
448.15 whether the fine was paid;

448.16 (4) final enforcement actions pursuant to chapter 14;

448.17 (5) orders for hearing, findings of fact and conclusions of law; and

448.18 (6) when the licensee and department agree to resolve the matter without a hearing,
448.19 the agreement and specific reasons for the agreement are public data.

448.20 Sec. 5. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
448.21 to read:

448.22 Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to
448.23 sections 144A.43 to 144A.482, the following data collected, created, or maintained by
448.24 the Department of Health are classified as confidential data on individuals as defined in
448.25 section 13.02, subdivision 3: active investigative data relating to the investigation of
448.26 potential violations of law by a licensee including data from the survey process before the
448.27 correction order is issued by the department.

448.28 Sec. 6. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
448.29 to read:

448.30 Subd. 6. **Release of private or confidential data.** For providers regulated pursuant
448.31 to sections 144A.43 to 144A.482, the department may release private or confidential data,
448.32 except Social Security numbers, to the appropriate state, federal, or local agency and law
448.33 enforcement office to enhance investigative or enforcement efforts or further a public

449.1 health protective process. Types of offices include Adult Protective Services, Office of the
449.2 Ombudsmen for Long-Term Care and Office of the Ombudsmen for Mental Health and
449.3 Developmental Disabilities, the health licensing boards, Department of Human Services,
449.4 county or city attorney's offices, police, and local or county public health offices.

449.5 Sec. 7. Minnesota Statutes 2012, section 144A.43, is amended to read:

449.6 **144A.43 DEFINITIONS.**

449.7 Subdivision 1. **Applicability.** The definitions in this section apply to sections
449.8 144.699, subdivision 2, and 144A.43 to ~~144A.47~~ 144A.482.

449.9 Subd. 1a. **Agent.** "Agent" means the person upon whom all notices and orders shall
449.10 be served and who is authorized to accept service of notices and orders on behalf of
449.11 the home care provider.

449.12 Subd. 1b. **Applicant.** "Applicant" means an individual, organization, association,
449.13 corporation, unit of government, or other entity that applies for a temporary license,
449.14 license, or renewal of the applicant's home care provider license under section 144A.472.

449.15 Subd. 1c. **Client.** "Client" means a person to whom home care services are provided.

449.16 Subd. 1d. **Client record.** "Client record" means all records that document
449.17 information about the home care services provided to the client by the home care provider.

449.18 Subd. 1e. **Client representative.** "Client representative" means a person who,
449.19 because of the client's needs, makes decisions about the client's care on behalf of the
449.20 client. A client representative may be a guardian, health care agent, family member, or
449.21 other agent of the client. Nothing in this section expands or diminishes the rights of
449.22 persons to act on behalf of clients under other law.

449.23 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

449.24 Subd. 2a. **Controlled substance.** "Controlled substance" has the meaning given
449.25 in section 152.01, subdivision 4.

449.26 Subd. 2b. **Department.** "Department" means the Minnesota Department of Health.

449.27 Subd. 2c. **Dietary supplement.** "Dietary supplement" means a product taken
449.28 by mouth that contains a dietary ingredient intended to supplement the diet. Dietary
449.29 ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and
449.30 substances such as enzymes, organ tissue, glandulars, or metabolites.

449.31 Subd. 2d. **Dietitian.** "Dietitian" is a person licensed under sections 148.621 to
449.32 148.633.

449.33 Subd. 2e. **Dietetics or nutrition practice.** "Dietetics or nutrition practice" is
449.34 performed by a licensed dietitian or licensed nutritionist and includes the activities of
449.35 assessment, setting priorities and objectives, providing nutrition counseling, developing

450.1 and implementing nutrition care services, and evaluating and maintaining appropriate
450.2 standards of quality of nutrition care under sections 148.621 to 148.633.

450.3 Subd. 3. **Home care service.** "Home care service" means any of the following
450.4 services ~~when delivered in a place of residence to~~ the home of a person whose illness,
450.5 disability, or physical condition creates a need for the service:

450.6 ~~(1) nursing services, including the services of a home health aide;~~

450.7 ~~(2) personal care services not included under sections 148.171 to 148.285;~~

450.8 ~~(3) physical therapy;~~

450.9 ~~(4) speech therapy;~~

450.10 ~~(5) respiratory therapy;~~

450.11 ~~(6) occupational therapy;~~

450.12 ~~(7) nutritional services;~~

450.13 ~~(8) home management services when provided to a person who is unable to perform~~
450.14 ~~these activities due to illness, disability, or physical condition. Home management~~
450.15 ~~services include at least two of the following services: housekeeping, meal preparation,~~
450.16 ~~and shopping;~~

450.17 ~~(9) medical social services;~~

450.18 ~~(10) the provision of medical supplies and equipment when accompanied by the~~
450.19 ~~provision of a home care service; and~~

450.20 ~~(11) other similar medical services and health-related support services identified by~~
450.21 ~~the commissioner in rule.~~

450.22 ~~"Home care service" does not include the following activities conducted by the~~
450.23 ~~commissioner of health or a board of health as defined in section 145A.02, subdivision 2:~~
450.24 ~~communicable disease investigations or testing; administering or monitoring a prescribed~~
450.25 ~~therapy necessary to control or prevent a communicable disease; or the monitoring~~
450.26 ~~of an individual's compliance with a health directive as defined in section 144.4172,~~
450.27 ~~subdivision 6.~~

450.28 (1) assistive tasks provided by unlicensed personnel;

450.29 (2) services provided by a registered nurse or licensed practical nurse, physical
450.30 therapist, respiratory therapist, occupational therapist, speech-language pathologist,
450.31 dietitian or nutritionist, or social worker;

450.32 (3) medication and treatment management services; or

450.33 (4) the provision of durable medical equipment services when provided with any of
450.34 the home care services listed in clauses (1) to (3).

450.35 Subd. 3a. **Hands-on assistance.** "Hands-on assistance" means physical help by
450.36 another person without which the client is not able to perform the activity.

451.1 Subd. 3b. **Home.** "Home" means the client's temporary or permanent place of
451.2 residence.

451.3 Subd. 4. **Home care provider.** "Home care provider" means an individual,
451.4 organization, association, corporation, unit of government, or other entity that is regularly
451.5 engaged in the delivery of at least one home care service, directly ~~or by contractual~~
451.6 ~~arrangement, of home care services~~ in a client's home for a fee and who has a valid current
451.7 temporary license or license issued under sections 144A.43 to 144A.482. At least one
451.8 ~~home care service must be provided directly, although additional home care services may~~
451.9 ~~be provided by contractual arrangements.~~ "Home care provider" does not include:

451.10 (1) ~~any home care or nursing services conducted by and for the adherents of any~~
451.11 ~~recognized church or religious denomination for the purpose of providing care and~~
451.12 ~~services for those who depend upon spiritual means, through prayer alone, for healing;~~

451.13 (2) ~~an individual who only provides services to a relative;~~

451.14 (3) ~~an individual not connected with a home care provider who provides assistance~~
451.15 ~~with home management services or personal care needs if the assistance is provided~~
451.16 ~~primarily as a contribution and not as a business;~~

451.17 (4) ~~an individual not connected with a home care provider who shares housing with~~
451.18 ~~and provides primarily housekeeping or homemaking services to an elderly or disabled~~
451.19 ~~person in return for free or reduced-cost housing;~~

451.20 (5) ~~an individual or agency providing home-delivered meal services;~~

451.21 (6) ~~an agency providing senior companion services and other older American~~
451.22 ~~volunteer programs established under the Domestic Volunteer Service Act of 1973,~~
451.23 ~~Public Law 98-288;~~

451.24 (7) ~~an employee of a nursing home licensed under this chapter or an employee of a~~
451.25 ~~boarding care home licensed under sections 144.50 to 144.56 who responds to occasional~~
451.26 ~~emergency calls from individuals residing in a residential setting that is attached to or~~
451.27 ~~located on property contiguous to the nursing home or boarding care home;~~

451.28 (8) ~~a member of a professional corporation organized under chapter 319B that does~~
451.29 ~~not regularly offer or provide home care services as defined in subdivision 3;~~

451.30 (9) ~~the following organizations established to provide medical or surgical services~~
451.31 ~~that do not regularly offer or provide home care services as defined in subdivision 3:~~
451.32 ~~a business trust organized under sections 318.01 to 318.04, a nonprofit corporation~~
451.33 ~~organized under chapter 317A, a partnership organized under chapter 323, or any other~~
451.34 ~~entity determined by the commissioner;~~

452.1 ~~(10) an individual or agency that provides medical supplies or durable medical~~
452.2 ~~equipment, except when the provision of supplies or equipment is accompanied by a~~
452.3 ~~home care service;~~

452.4 ~~(11) an individual licensed under chapter 147; or~~

452.5 ~~(12) an individual who provides home care services to a person with a developmental~~
452.6 ~~disability who lives in a place of residence with a family, foster family, or primary caregiver.~~

452.7 ~~Subd. 5. **Medication reminder.** "Medication reminder" means providing a verbal~~
452.8 ~~or visual reminder to a client to take medication. This includes bringing the medication~~
452.9 ~~to the client and providing liquids or nutrition to accompany medication that a client is~~
452.10 ~~self-administering.~~

452.11 ~~Subd. 6. **License.** "License" means a basic or comprehensive home care license~~
452.12 ~~issued by the commissioner to a home care provider.~~

452.13 ~~Subd. 7. **Licensed health professional.** "Licensed health professional" means a~~
452.14 ~~person, other than a registered nurse or licensed practical nurse, who provides home care~~
452.15 ~~services within the scope of practice of the person's health occupation license, registration,~~
452.16 ~~or certification as regulated and who is licensed by the appropriate Minnesota state board~~
452.17 ~~or agency.~~

452.18 ~~Subd. 8. **Licensee.** "Licensee" means a home care provider that is licensed under~~
452.19 ~~this chapter.~~

452.20 ~~Subd. 9. **Managerial official.** "Managerial official" means an administrator,~~
452.21 ~~director, officer, trustee, or employee of a home care provider, however designated, who~~
452.22 ~~has the authority to establish or control business policy.~~

452.23 ~~Subd. 10. **Medication.** "Medication" means a prescription or over-the-counter drug.~~
452.24 ~~For purposes of this chapter only, medication includes dietary supplements.~~

452.25 ~~Subd. 11. **Medication administration.** "Medication administration" means~~
452.26 ~~performing a set of tasks to ensure a client takes medications, and includes the following:~~

452.27 ~~(1) checking the client's medication record;~~

452.28 ~~(2) preparing the medication as necessary;~~

452.29 ~~(3) administering the medication to the client;~~

452.30 ~~(4) documenting the administration or reason for not administering the medication;~~

452.31 ~~and~~

452.32 ~~(5) reporting to a nurse any concerns about the medication, the client, or the client's~~
452.33 ~~refusal to take the medication.~~

452.34 ~~Subd. 12. **Medication management.** "Medication management" means the~~
452.35 ~~provision of any of the following medication-related services to a client:~~

452.36 ~~(1) performing medication setup;~~

- 453.1 (2) administering medication;
- 453.2 (3) storing and securing medications;
- 453.3 (4) documenting medication activities;
- 453.4 (5) verifying and monitoring effectiveness of systems to ensure safe handling and
- 453.5 administration;
- 453.6 (6) coordinating refills;
- 453.7 (7) handling and implementing changes to prescriptions;
- 453.8 (8) communicating with the pharmacy about the client's medications; and
- 453.9 (9) coordinating and communicating with the prescriber.

453.10 Subd. 13. **Medication setup.** "Medication setup" means arranging medications by a

453.11 nurse, pharmacy, or authorized prescriber for later administration by the client or by

453.12 comprehensive home care staff.

453.13 Subd. 14. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to

453.14 148.285.

453.15 Subd. 15. **Occupational therapist.** "Occupational therapist" means a person who is

453.16 licensed under sections 148.6401 to 148.6450.

453.17 Subd. 16. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is

453.18 not required by federal law to bear the symbol "Rx only."

453.19 Subd. 17. **Owner.** "Owner" means a proprietor, general partner, limited partner who

453.20 has five percent or more equity interest in a limited partnership, a person who owns or

453.21 controls voting stock in a corporation in an amount equal to or greater than five percent of

453.22 the shares issued and outstanding, or a corporation that owns equity interest in a licensee

453.23 or applicant for a license.

453.24 Subd. 18. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01,

453.25 subdivision 3.

453.26 Subd. 19. **Physical therapist.** "Physical therapist" means a person who is licensed

453.27 under sections 148.65 to 148.78.

453.28 Subd. 20. **Physician.** "Physician" means a person who is licensed under chapter 147.

453.29 Subd. 21. **Prescriber.** "Prescriber" means a person who is authorized by sections

453.30 148.235; 151.01, subdivision 23; and 151.37 to prescribe prescription drugs.

453.31 Subd. 22. **Prescription.** "Prescription" has the meaning given in section 151.01,

453.32 subdivision 16.

453.33 Subd. 23. **Regularly scheduled.** "Regularly scheduled" means ordered or planned

453.34 to be completed at predetermined times or according to a predetermined routine.

453.35 Subd. 24. **Reminder.** "Reminder" means providing a verbal or visual reminder

453.36 to a client.

454.1 Subd. 25. **Respiratory therapist.** "Respiratory therapist" means a person who
454.2 is licensed under chapter 147C.

454.3 Subd. 26. **Revenues.** "Revenues" means all money received by a licensee derived
454.4 from the provision of home care services, including fees for services and appropriations
454.5 of public money for home care services.

454.6 Subd. 27. **Service plan.** "Service plan" means the written plan between the client or
454.7 client's representative and the temporary licensee or licensee about the services that will
454.8 be provided to the client.

454.9 Subd. 28. **Social worker.** "Social worker" means a person who is licensed under
454.10 chapter 148D or 148E.

454.11 Subd. 29. **Speech-language pathologist.** "Speech-language pathologist" has the
454.12 meaning given in section 148.512.

454.13 Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another
454.14 person within arm's reach to minimize the risk of injury while performing daily activities
454.15 through physical intervention or cuing.

454.16 Subd. 31. **Substantial compliance.** "Substantial compliance" means complying
454.17 with the requirements in this chapter sufficiently to prevent unacceptable health or safety
454.18 risks to the home care client.

454.19 Subd. 32. **Survey.** "Survey" means an inspection of a licensee or applicant for
454.20 licensure for compliance with this chapter.

454.21 Subd. 33. **Surveyor.** "Surveyor" means a staff person of the department authorized
454.22 to conduct surveys of home care providers and applicants.

454.23 Subd. 34. **Temporary license.** "Temporary license" means the initial basic or
454.24 comprehensive home care license the department issues after approval of a complete
454.25 written application and before the department completes the temporary license survey and
454.26 determines that the temporary licensee is in substantial compliance.

454.27 Subd. 35. **Treatment or therapy.** "Treatment" or "therapy" means the provision
454.28 of care, other than medications, ordered or prescribed by a licensed health professional
454.29 provided to a client to cure, rehabilitate, or ease symptoms.

454.30 Subd. 36. **Unit of government.** "Unit of government" means every city, county,
454.31 town, school district, other political subdivisions of the state, or agency of the state or
454.32 federal government, which includes any instrumentality of a unit of government.

454.33 Subd. 37. **Unlicensed personnel.** "Unlicensed personnel" are individuals not
454.34 otherwise licensed or certified by a governmental health board or agency who provide
454.35 home care services in the client's home.

454.36 Subd. 38. **Verbal.** "Verbal" means oral and not in writing.

455.1 Sec. 8. Minnesota Statutes 2012, section 144A.44, is amended to read:

455.2 **144A.44 HOME CARE BILL OF RIGHTS.**

455.3 Subdivision 1. **Statement of rights.** A person who receives home care services
455.4 has these rights:

455.5 (1) the right to receive written information about rights ~~in advance of~~ before
455.6 ~~receiving care or during the initial evaluation visit before the initiation of treatment~~
455.7 services, including what to do if rights are violated;

455.8 (2) the right to receive care and services according to a suitable and up-to-date plan,
455.9 and subject to accepted health care, medical or nursing standards, to take an active part
455.10 ~~in creating and changing the plan~~ developing, modifying, and evaluating care the plan
455.11 and services;

455.12 (3) the right to be told ~~in advance of~~ before receiving care ~~about the services that will~~
455.13 ~~be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will
455.14 be providing the services, the frequency of visits proposed to be furnished, other choices
455.15 that are available for addressing home care needs, and ~~the consequences of these choices~~
455.16 ~~including~~ the potential consequences of refusing these services;

455.17 (4) the right to be told in advance of any ~~change~~ recommended changes by the
455.18 provider in the service plan of care and to take an active part in any ~~change~~ decisions
455.19 about changes to the service plan;

455.20 (5) the right to refuse services or treatment;

455.21 (6) the right to know, ~~in advance~~ before receiving services or during the initial
455.22 visit, any limits to the services available from a home care provider, ~~and the provider's~~
455.23 ~~grounds for a termination of services~~;

455.24 (7) ~~the right to know in advance of receiving care whether the services are covered~~
455.25 ~~by health insurance, medical assistance, or other health programs, the charges for services~~
455.26 ~~that will not be covered by Medicare, and the charges that the individual may have to pay~~;

455.27 (8) ~~(7)~~ the right to know be told before services are initiated what the provider
455.28 charges are for the services, no matter who will be paying the bill; to what extent payment
455.29 may be expected from health insurance, public programs, or other sources, if known; and
455.30 what charges the client may be responsible for paying;

455.31 (9) ~~(8)~~ the right to know that there may be other services available in the community,
455.32 including other home care services and providers, and to know where to ~~go for~~ find
455.33 information about these services;

455.34 (10) ~~(9)~~ the right to choose freely among available providers and to change providers
455.35 after services have begun, within the limits of health insurance, long-term care insurance,
455.36 medical assistance, or other health programs;

456.1 ~~(11)~~ (10) the right to have personal, financial, and medical information kept private,
456.2 and to be advised of the provider's policies and procedures regarding disclosure of such
456.3 information;

456.4 ~~(12)~~ (11) the right to ~~be allowed~~ access to the client's own records and written
456.5 information from those records in accordance with sections 144.291 to 144.298;

456.6 ~~(13)~~ (12) the right to be served by people who are properly trained and competent
456.7 to perform their duties;

456.8 ~~(14)~~ (13) the right to be treated with courtesy and respect, and to have the ~~patient's~~
456.9 client's property treated with respect;

456.10 ~~(15)~~ (14) the right to be free from physical and verbal abuse, neglect, financial
456.11 exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and
456.12 the Maltreatment of Minors Act;

456.13 ~~(16)~~ (15) the right to reasonable, advance notice of changes in services or charges;
456.14 including;

456.15 (16) the right to know the provider's reason for termination of services;

456.16 (17) the right to at least ten days' advance notice of the termination of a service by a
456.17 provider, except in cases where:

456.18 ~~(i) the recipient of services~~ client engages in conduct that significantly alters the
456.19 ~~conditions of employment as specified in the employment contract between terms of~~
456.20 the service plan with the home care provider ~~and the individual providing home care~~
456.21 ~~services, or creates;~~

456.22 ~~(ii) the client, person who lives with the client, or others create~~ an abusive or unsafe
456.23 work environment for the ~~individual~~ person providing home care services; or

456.24 ~~(ii) (iii) an emergency for the informal caregiver or a significant change in the~~
456.25 ~~recipient's~~ client's condition has resulted in service needs that exceed the current service
456.26 ~~provider agreement~~ plan and that cannot be safely met by the home care provider;

456.27 ~~(17)~~ (18) the right to a coordinated transfer when there will be a change in the
456.28 provider of services;

456.29 ~~(18)~~ (19) the right to ~~voice grievances regarding treatment or care that is~~ complain
456.30 about services that are provided, or fails to be, furnished, or regarding fail to be provided,
456.31 and the lack of courtesy or respect to the ~~patient~~ client or the ~~patient's~~ client's property;

456.32 ~~(19)~~ (20) the right to know how to contact an individual associated with the home
456.33 care provider who is responsible for handling problems and to have the home care provider
456.34 investigate and attempt to resolve the grievance or complaint;

456.35 ~~(20)~~ (21) the right to know the name and address of the state or county agency to
456.36 contact for additional information or assistance; and

457.1 (21) (22) the right to assert these rights personally, or have them asserted by
457.2 the ~~patient's family or guardian when the patient has been judged incompetent,~~ client's
457.3 representative or by anyone on behalf of the client, without retaliation.

457.4 Subd. 2. **Interpretation and enforcement of rights.** These rights are established
457.5 for the benefit of ~~persons~~ clients who receive home care services. "~~Home care services~~"
457.6 ~~means home care services as defined in section 144A.43, subdivision 3, and unlicensed~~
457.7 ~~personal care assistance services, including services covered by medical assistance under~~
457.8 ~~section 256B.0625, subdivision 19a. All home care providers, including those exempted~~
457.9 ~~under section 144A.471, must comply with this section. The commissioner shall enforce~~
457.10 ~~this section and the home care bill of rights requirement against home care providers~~
457.11 ~~exempt from licensure in the same manner as for licensees. A home care provider may~~
457.12 ~~not request or require a person client to surrender any of these rights as a condition of~~
457.13 ~~receiving services. A guardian or conservator or, when there is no guardian or conservator,~~
457.14 ~~a designated person, may seek to enforce these rights. This statement of rights does not~~
457.15 replace or diminish other rights and liberties that may exist relative to ~~persons~~ clients
457.16 receiving home care services, persons providing home care services, or providers licensed
457.17 under ~~Laws 1987, chapter 378. A copy of these rights must be provided to an individual~~
457.18 ~~at the time home care services, including personal care assistance services, are initiated.~~
457.19 ~~The copy shall also contain the address and phone number of the Office of Health Facility~~
457.20 ~~Complaints and the Office of Ombudsman for Long-Term Care and a brief statement~~
457.21 ~~describing how to file a complaint with these offices. Information about how to contact~~
457.22 ~~the Office of Ombudsman for Long-Term Care shall be included in notices of change in~~
457.23 ~~client fees and in notices where home care providers initiate transfer or discontinuation of~~
457.24 ~~services sections 144A.43 to 144A.482.~~

457.25 Sec. 9. Minnesota Statutes 2012, section 144A.45, is amended to read:

457.26 **144A.45 REGULATION OF HOME CARE SERVICES.**

457.27 Subdivision 1. **Rules Regulations.** The commissioner shall ~~adopt rules for the~~
457.28 ~~regulation of~~ regulate home care providers pursuant to sections 144A.43 to ~~144A.47~~
457.29 ~~144A.482.~~ 144A.482. The ~~rules~~ regulations shall include the following:

457.30 (1) provisions to assure, to the extent possible, the health, safety ~~and,~~ well-being,
457.31 and appropriate treatment of persons who receive home care services while respecting
457.32 a client's autonomy and choice;

457.33 (2) requirements that home care providers furnish the commissioner with specified
457.34 information necessary to implement sections 144A.43 to ~~144A.47~~ 144A.482;

458.1 (3) standards of training of home care provider personnel, ~~which may vary according~~
458.2 ~~to the nature of the services provided or the health status of the consumer;~~

458.3 (4) standards for provision of home care services;

458.4 ~~(4) (5) standards for medication management which may vary according to the~~
458.5 ~~nature of the services provided, the setting in which the services are provided, or the~~
458.6 ~~status of the consumer. Medication management includes the central storage, handling,~~
458.7 ~~distribution, and administration of medications;~~

458.8 ~~(5) (6) standards for supervision of home care services requiring supervision by a~~
458.9 ~~registered nurse or other appropriate health care professional which must occur on site~~
458.10 ~~at least every 62 days, or more frequently if indicated by a clinical assessment, and in~~
458.11 ~~accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that a~~
458.12 ~~person performing home care aide tasks for a class B licensee providing paraprofessional~~
458.13 ~~services does not require nursing supervision;~~

458.14 ~~(6) (7) standards for client evaluation or assessment which may vary according to~~
458.15 ~~the nature of the services provided or the status of the consumer;~~

458.16 ~~(7) (8) requirements for the involvement of a consumer's physician client's health~~
458.17 ~~care provider, the documentation of physicians' health care providers' orders, if required,~~
458.18 ~~and the consumer's treatment client's service plan, and;~~

458.19 ~~(9) the maintenance of accurate, current clinical client records;~~

458.20 ~~(8) (10) the establishment of different classes basic and comprehensive levels of~~
458.21 ~~licenses for different types of providers and different standards and requirements for~~
458.22 ~~different kinds of home care based on services provided; and~~

458.23 ~~(9) operating procedures required to implement (11) provisions to enforce these~~
458.24 ~~regulations and the home care bill of rights.~~

458.25 ~~Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota~~
458.26 ~~Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting~~
458.27 ~~toileting, transfers, and ambulation if the client is ambulatory and if the client has no~~
458.28 ~~serious acute illness or infectious disease.~~

458.29 ~~Subd. 1b. **Home health aide qualifications.** Notwithstanding the provisions of~~
458.30 ~~Minnesota Rules, part 4668.0100, subpart 5, a person may perform home health aide tasks~~
458.31 ~~if the person maintains current registration as a nursing assistant on the Minnesota nursing~~
458.32 ~~assistant registry. Maintaining current registration on the Minnesota nursing assistant~~
458.33 ~~registry satisfies the documentation requirements of Minnesota Rules, part 4668.0110,~~
458.34 ~~subpart 3.~~

458.35 ~~Subd. 2. **Regulatory functions.** (a) The commissioner shall:~~

459.1 (1) ~~evaluate, monitor, and license, survey, and monitor without advance notice, home~~
459.2 ~~care providers in accordance with sections 144A.45 to 144A.47~~ 144A.43 to 144A.482;

459.3 (2) ~~inspect the office and records of a provider during regular business hours without~~
459.4 ~~advance notice to the home care provider;~~

459.5 (2) survey every temporary licensee within one year of the temporary license issuance
459.6 date subject to the temporary licensee providing home care services to a client or clients;

459.7 (3) survey all licensed home care providers on an interval that will promote the
459.8 health and safety of clients;

459.9 (3) (4) ~~with the consent of the consumer client,~~ visit the home where services are
459.10 being provided;

459.11 (4) (5) issue correction orders and assess civil penalties in accordance with section
459.12 144.653, subdivisions 5 to 8, for violations of sections 144A.43 to 144A.47 ~~or the rules~~
459.13 ~~adopted under those sections~~ 144A.482;

459.14 (5) (6) take action as authorized in section 144A.46, ~~subdivision 3~~ 144A.475; and

459.15 (6) (7) take other action reasonably required to accomplish the purposes of sections
459.16 144A.43 to 144A.47 144A.482.

459.17 (b) ~~In the exercise of the authority granted in sections 144A.43 to 144A.47, the~~
459.18 ~~commissioner shall comply with the applicable requirements of section 144.122, the~~
459.19 ~~Government Data Practices Act, and the Administrative Procedure Act.~~

459.20 Subd. 4. **Medicaid reimbursement.** ~~Notwithstanding the provisions of section~~
459.21 ~~256B.37 or state plan requirements to the contrary, certification by the federal Medicare~~
459.22 ~~program must not be a requirement of Medicaid payment for services delivered under~~
459.23 ~~section 144A.4605.~~

459.24 Subd. 5. **Home care providers; services for Alzheimer's disease or related**
459.25 **disorder.** (a) ~~If a home care provider licensed under section 144A.46 or 144A.4605 markets~~
459.26 ~~or otherwise promotes services for persons with Alzheimer's disease or related disorders,~~
459.27 ~~the facility's direct care staff and their supervisors must be trained in dementia care.~~

459.28 (b) ~~Areas of required training include:~~

459.29 (1) ~~an explanation of Alzheimer's disease and related disorders;~~

459.30 (2) ~~assistance with activities of daily living;~~

459.31 (3) ~~problem solving with challenging behaviors; and~~

459.32 (4) ~~communication skills.~~

459.33 (c) ~~The licensee shall provide to consumers in written or electronic form a~~
459.34 ~~description of the training program, the categories of employees trained, the frequency~~
459.35 ~~of training, and the basic topics covered.~~

460.1 Sec. 10. [144A.471] HOME CARE PROVIDER AND HOME CARE SERVICES.

460.2 Subdivision 1. License required. A home care provider may not open, operate,
460.3 manage, conduct, maintain, or advertise itself as a home care provider or provide home
460.4 care services in Minnesota without a temporary or current home care provider license
460.5 issued by the commissioner of health.

460.6 Subd. 2. Determination of direct home care service. (a) "Direct home care
460.7 service" means a home care service provided to a client by the home care provider or its
460.8 employees, and not by contract. Factors that must be considered in determining whether
460.9 an individual or a business entity provides at least one home care service directly include,
460.10 but are not limited to, whether the individual or business entity:

460.11 (1) has the right to control, and does control, the types of services provided;

460.12 (2) has the right to control, and does control, when and how the services are provided;

460.13 (3) establishes the charges;

460.14 (4) collects fees from the clients or receives payment from third-party payers on
460.15 the clients' behalf;

460.16 (5) pays individuals providing services compensation on an hourly, weekly, or
460.17 similar basis;

460.18 (6) treats the individuals providing services as employees for the purposes of payroll
460.19 taxes and workers' compensation insurance; and

460.20 (7) holds itself out as a provider of home care services or acts in a manner that
460.21 leads clients or potential clients to believe that it is a home care provider providing home
460.22 care services.

460.23 (b) None of the factors listed in this subdivision is solely determinative.

460.24 Subd. 3. Determination of regularly engaged. (a) "Regularly engaged" means
460.25 providing, or offering to provide, home care services as a regular part of a business. The
460.26 following factors must be considered by the commissioner in determining whether an
460.27 individual or a business entity is regularly engaged in providing home care services:

460.28 (1) whether the individual or business entity states or otherwise promotes that the
460.29 individual or business entity provides home care services;

460.30 (2) whether persons receiving home care services constitute a substantial part of the
460.31 individual's or the business entity's clientele; and

460.32 (3) whether the home care services provided are other than occasional or incidental
460.33 to the provision of services other than home care services.

460.34 (b) None of the factors listed in this subdivision is solely determinative.

460.35 Subd. 4. Penalties for operating without license. A person involved in the
460.36 management, operation, or control of a home care provider that operates without an

461.1 appropriate license is guilty of a misdemeanor. This section does not apply to a person
461.2 who has no legal authority to affect or change decisions related to the management,
461.3 operation, or control of a home care provider.

461.4 Subd. 5. **Basic and comprehensive levels of licensure.** An applicant seeking
461.5 to become a home care provider must apply for either a basic or comprehensive home
461.6 care license.

461.7 Subd. 6. **Basic home care license provider.** Home care services that can be
461.8 provided with a basic home care license are assistive tasks provided by licensed or
461.9 unlicensed personnel that include:

461.10 (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting,
461.11 and bathing;

461.12 (2) providing standby assistance;

461.13 (3) providing verbal or visual reminders to the client to take regularly scheduled
461.14 medication, which includes bringing the client previously set-up medication, medication
461.15 in original containers, or liquid or food to accompany the medication;

461.16 (4) providing verbal or visual reminders to the client to perform regularly scheduled
461.17 treatments and exercises;

461.18 (5) preparing modified diets ordered by a licensed health professional; and

461.19 (6) assisting with laundry, housekeeping, meal preparation, shopping, or other
461.20 household chores and services if the provider is also providing at least one of the activities
461.21 in clauses (1) to (5)

461.22 Subd. 7. **Comprehensive home care license provider.** Home care services that
461.23 may be provided with a comprehensive home care license include any of the basic home
461.24 care services listed in subdivision 6, and one or more of the following:

461.25 (1) services of an advanced practice nurse, registered nurse, licensed practical
461.26 nurse, physical therapist, respiratory therapist, occupational therapist, speech-language
461.27 pathologist, dietitian or nutritionist, or social worker;

461.28 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a
461.29 licensed health professional within the person's scope of practice;

461.30 (3) medication management services;

461.31 (4) hands-on assistance with transfers and mobility;

461.32 (5) assisting clients with eating when the clients have complicating eating problems
461.33 as identified in the client record or through an assessment such as difficulty swallowing,
461.34 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
461.35 instruments to be fed; or

461.36 (6) providing other complex or specialty health care services.

462.1 Subd. 8. Exemptions from home care services licensure. (a) Except as otherwise
462.2 provided in this chapter, home care services that are provided by the state, counties, or
462.3 other units of government must be licensed under this chapter.

462.4 (b) An exemption under this subdivision does not excuse the exempted individual or
462.5 organization from complying with applicable provisions of the home care bill of rights
462.6 in section 144A.44. The following individuals or organizations are exempt from the
462.7 requirement to obtain a home care provider license:

462.8 (1) an individual or organization that offers, provides, or arranges for personal care
462.9 assistance services under the medical assistance program as authorized under sections
462.10 256B.04, subdivision 16; 256B.0625, subdivision 19a; and 256B.0659;

462.11 (2) a provider that is licensed by the commissioner of human services to provide
462.12 semi-independent living services for persons with developmental disabilities under section
462.13 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

462.14 (3) a provider that is licensed by the commissioner of human services to provide
462.15 home and community-based services for persons with developmental disabilities under
462.16 section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

462.17 (4) an individual or organization that provides only home management services, if
462.18 the individual or organization is registered under section 144A.482; or

462.19 (5) an individual who is licensed in this state as a nurse, dietitian, social worker,
462.20 occupational therapist, physical therapist, or speech-language pathologist who provides
462.21 health care services in the home independently and not through any contractual or
462.22 employment relationship with a home care provider or other organization.

462.23 Subd. 9. Exclusions from home care licensure. The following are excluded from
462.24 home care licensure and are not required to provide the home care bill of rights:

462.25 (1) an individual or business entity providing only coordination of home care that
462.26 includes one or more of the following:

462.27 (i) determination of whether a client needs home care services, or assisting a client
462.28 in determining what services are needed;

462.29 (ii) referral of clients to a home care provider;

462.30 (iii) administration of payments for home care services; or

462.31 (iv) administration of a health care home established under section 256B.0751;

462.32 (2) an individual who is not an employee of a licensed home care provider if the
462.33 individual:

462.34 (i) only provides services as an independent contractor to one or more licensed
462.35 home care providers;

462.36 (ii) provides no services under direct agreements or contracts with clients; and

- 463.1 (iii) is contractually bound to perform services in compliance with the contracting
463.2 home care provider's policies and service plans;
- 463.3 (3) a business that provides staff to home care providers, such as a temporary
463.4 employment agency, if the business:
- 463.5 (i) only provides staff under contract to licensed or exempt providers;
463.6 (ii) provides no services under direct agreements with clients; and
463.7 (iii) is contractually bound to perform services under the contracting home care
463.8 provider's direction and supervision;
- 463.9 (4) any home care services conducted by and for the adherents of any recognized
463.10 church or religious denomination for its members through spiritual means, or by prayer
463.11 for healing;
- 463.12 (5) an individual who only provides home care services to a relative;
463.13 (6) an individual not connected with a home care provider that provides assistance
463.14 with basic home care needs if the assistance is provided primarily as a contribution and
463.15 not as a business;
- 463.16 (7) an individual not connected with a home care provider that shares housing with
463.17 and provides primarily housekeeping or homemaking services to an elderly or disabled
463.18 person in return for free or reduced-cost housing;
- 463.19 (8) an individual or provider providing home-delivered meal services;
463.20 (9) an individual providing senior companion services and other older American
463.21 volunteer programs (OAVP) established under the Domestic Volunteer Service Act of
463.22 1973, United States Code, title 42, chapter 66;
- 463.23 (10) an employee of a nursing home licensed under this chapter or an employee of a
463.24 boarding care home licensed under sections 144.50 to 144.56 who responds to occasional
463.25 emergency calls from individuals residing in a residential setting that is attached to or
463.26 located on property contiguous to the nursing home or boarding care home;
- 463.27 (11) a member of a professional corporation organized under chapter 319B that
463.28 does not regularly offer or provide home care services as defined in section 144A.43,
463.29 subdivision 3;
- 463.30 (12) the following organizations established to provide medical or surgical services
463.31 that do not regularly offer or provide home care services as defined in section 144A.43,
463.32 subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit
463.33 corporation organized under chapter 317A, a partnership organized under chapter 323, or
463.34 any other entity determined by the commissioner;

464.1 (13) an individual or agency that provides medical supplies or durable medical
464.2 equipment, except when the provision of supplies or equipment is accompanied by a
464.3 home care service;

464.4 (14) a physician licensed under chapter 147;

464.5 (15) an individual who provides home care services to a person with a developmental
464.6 disability who lives in a place of residence with a family, foster family, or primary caregiver;

464.7 (16) a business that only provides services that are primarily instructional and not
464.8 medical services or health-related support services;

464.9 (17) an individual who performs basic home care services for no more than 14 hours
464.10 each calendar week to no more than one client;

464.11 (18) an individual or business licensed as hospice as defined in sections 144A.75 to
464.12 144A.755 who is not providing home care services independent of hospice service;

464.13 (19) activities conducted by the commissioner of health or a board of health as
464.14 defined in section 145A.02, subdivision 2, including communicable disease investigations
464.15 or testing; or

464.16 (20) administering or monitoring a prescribed therapy necessary to control or
464.17 prevent a communicable disease, or the monitoring of an individual's compliance with a
464.18 health directive as defined in section 144.4172, subdivision 6.

464.19 Sec. 11. **[144A.472] HOME CARE PROVIDER LICENSE; APPLICATION**
464.20 **AND RENEWAL.**

464.21 Subdivision 1. **License applications.** Each application for a home care provider
464.22 license must include information sufficient to show that the applicant meets the
464.23 requirements of licensure, including:

464.24 (1) the applicant's name, e-mail address, physical address, and mailing address,
464.25 including the name of the county in which the applicant resides and has a principal
464.26 place of business;

464.27 (2) the initial license fee in the amount specified in subdivision 7;

464.28 (3) the e-mail address, physical address, mailing address, and telephone number of
464.29 the principal administrative office;

464.30 (4) the e-mail address, physical address, mailing address, and telephone number of
464.31 each branch office, if any;

464.32 (5) the names, e-mail and mailing addresses, and telephone numbers of all owners
464.33 and managerial officials;

- 465.1 (6) documentation of compliance with the background study requirements of section
465.2 144A.476 for all persons involved in the management, operation, or control of the home
465.3 care provider;
- 465.4 (7) documentation of a background study as required by section 144.057 for any
465.5 individual seeking employment, paid or volunteer, with the home care provider;
- 465.6 (8) evidence of workers' compensation coverage as required by sections 176.181
465.7 and 176.182;
- 465.8 (9) documentation of liability coverage, if the provider has it;
- 465.9 (10) identification of the license level the provider is seeking;
- 465.10 (11) documentation that identifies the managerial official who is in charge of
465.11 day-to-day operations and attestation that the person has reviewed and understands the
465.12 home care provider regulations;
- 465.13 (12) documentation that the applicant has designated one or more owners,
465.14 managerial officials, or employees as an agent or agents, which shall not affect the legal
465.15 responsibility of any other owner or managerial official under this chapter;
- 465.16 (13) the signature of the officer or managing agent on behalf of an entity, corporation,
465.17 association, or unit of government;
- 465.18 (14) verification that the applicant has the following policies and procedures in place
465.19 so that if a license is issued, the applicant will implement the policies and procedures
465.20 and keep them current:
- 465.21 (i) requirements in sections 626.556, reporting of maltreatment of minors, and
465.22 626.557, reporting of maltreatment of vulnerable adults;
- 465.23 (ii) conducting and handling background studies on employees;
- 465.24 (iii) orientation, training, and competency evaluations of home care staff, and a
465.25 process for evaluating staff performance;
- 465.26 (iv) handling complaints from clients, family members, or client representatives
465.27 regarding staff or services provided by staff;
- 465.28 (v) conducting initial evaluation of clients' needs and the providers' ability to provide
465.29 those services;
- 465.30 (vi) conducting initial and ongoing client evaluations and assessments and how
465.31 changes in a client's condition are identified, managed, and communicated to staff and
465.32 other health care providers as appropriate;
- 465.33 (vii) orientation to and implementation of the home care client bill of rights;
- 465.34 (viii) infection control practices;
- 465.35 (ix) reminders for medications, treatments, or exercises, if provided; and

466.1 (x) conducting appropriate screenings, or documentation of prior screenings, to
466.2 show that staff are free of tuberculosis, consistent with current United States Centers for
466.3 Disease Control and Prevention standards; and

466.4 (15) other information required by the department.

466.5 Subd. 2. **Comprehensive home care license applications.** In addition to the
466.6 information and fee required in subdivision 1, applicants applying for a comprehensive
466.7 home care license must also provide verification that the applicant has the following
466.8 policies and procedures in place so that if a license is issued, the applicant will implement
466.9 the policies and procedures in this subdivision and keep them current:

466.10 (1) conducting initial and ongoing assessments of the client's needs by a registered
466.11 nurse or appropriate licensed health professional, including how changes in the client's
466.12 conditions are identified, managed, and communicated to staff and other health care
466.13 providers, as appropriate;

466.14 (2) ensuring that nurses and licensed health professionals have current and valid
466.15 licenses to practice;

466.16 (3) medication and treatment management;

466.17 (4) delegation of home care tasks by registered nurses or licensed health professionals;

466.18 (5) supervision of registered nurses and licensed health professionals; and

466.19 (6) supervision of unlicensed personnel performing delegated home care tasks.

466.20 Subd. 3. **License renewal.** (a) Except as provided in section 144A.475, a license
466.21 may be renewed for a period of one year if the licensee satisfies the following:

466.22 (1) submits an application for renewal in the format provided by the commissioner
466.23 at least 30 days before expiration of the license;

466.24 (2) submits the renewal fee in the amount specified in subdivision 7;

466.25 (3) has provided home care services within the past 12 months;

466.26 (4) complies with sections 144A.43 to 144A.4798;

466.27 (5) provides information sufficient to show that the applicant meets the requirements
466.28 of licensure, including items required under subdivision 1;

466.29 (6) provides verification that all policies under subdivision 1 are current; and

466.30 (7) provides any other information deemed necessary by the commissioner.

466.31 (b) A renewal applicant who holds a comprehensive home care license must also
466.32 provide verification that policies listed under subdivision 2 are current.

466.33 Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately
466.34 licensed if the commissioner determines that the units cannot adequately share supervision
466.35 and administration of services from the main office.

467.1 Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license
467.2 issued by the commissioner may not be transferred to another party. Before acquiring
467.3 ownership of a home care provider business, a prospective applicant must apply for a
467.4 new temporary license. A change of ownership is a transfer of operational control to
467.5 a different business entity and includes:

- 467.6 (1) transfer of the business to a different or new corporation;
467.7 (2) in the case of a partnership, the dissolution or termination of the partnership under
467.8 chapter 323A, with the business continuing by a successor partnership or other entity;
467.9 (3) relinquishment of control of the provider to another party, including to a contract
467.10 management firm that is not under the control of the owner of the business' assets;
467.11 (4) transfer of the business by a sole proprietor to another party or entity; or
467.12 (5) in the case of a privately held corporation, the change in ownership or control of
467.13 50 percent or more of the outstanding voting stock.

467.14 Subd. 6. **Notification of changes of information.** The temporary licensee or
467.15 licensee shall notify the commissioner in writing within ten working days after any
467.16 change in the information required in subdivision 1, except the information required in
467.17 subdivision 1, clause (5), is required at the time of license renewal.

467.18 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial
467.19 applicant seeking a temporary home care licensure must submit the following application
467.20 fee to the commissioner along with a completed application:

- 467.21 (1) for a basic home care provider, \$2,100; or
467.22 (2) for a comprehensive home care provider, \$4,200.

467.23 (b) A home care provider who is filing a change of ownership as required under
467.24 subdivision 5 must submit the following application fee to the commissioner, along with
467.25 the documentation required for the change of ownership:

- 467.26 (1) for a basic home care provider, \$2,100; or
467.27 (2) for a comprehensive home care provider, \$4,200.

467.28 (c) A home care provider who is seeking to renew the provider's license shall pay a
467.29 fee to the commissioner based on revenues derived from the provision of home care
467.30 services during the calendar year prior to the year in which the application is submitted,
467.31 according to the following schedule:

467.32 License Renewal Fee

<u>Provider Annual Revenue</u>	<u>Fee</u>
467.33 <u>greater than \$1,500,000</u>	<u>\$6,625</u>
467.35 <u>greater than \$1,275,000 and no more than</u> 467.36 <u>\$1,500,000</u>	<u>\$5,797</u>

468.1	<u>greater than \$1,100,000 and no more than</u>	
468.2	<u>\$1,275,000</u>	<u>\$4,969</u>
468.3	<u>greater than \$950,000 and no more than</u>	
468.4	<u>\$1,100,000</u>	<u>\$4,141</u>
468.5	<u>greater than \$850,000 and no more than</u>	
468.6	<u>\$950,000</u>	<u>\$3,727</u>
468.7	<u>greater than \$750,000 and no more than</u>	
468.8	<u>\$850,000</u>	<u>\$3,313</u>
468.9	<u>greater than \$650,000 and no more than</u>	
468.10	<u>\$750,000</u>	<u>\$2,898</u>
468.11	<u>greater than \$550,000 and no more than</u>	
468.12	<u>\$650,000</u>	<u>\$2,485</u>
468.13	<u>greater than \$450,000 and no more than</u>	
468.14	<u>\$550,000</u>	<u>\$2,070</u>
468.15	<u>greater than \$350,000 and no more than</u>	
468.16	<u>\$450,000</u>	<u>\$1,656</u>
468.17	<u>greater than \$250,000 and no more than</u>	
468.18	<u>\$350,000</u>	<u>\$1,242</u>
468.19	<u>greater than \$100,000 and no more than</u>	
468.20	<u>\$250,000</u>	<u>\$828</u>
468.21	<u>greater than \$50,000 and no more than \$100,000</u>	<u>\$500</u>
468.22	<u>greater than \$25,000 and no more than \$50,000</u>	<u>\$400</u>
468.23	<u>no more than \$25,000</u>	<u>\$200</u>

468.24 (d) If requested, the home care provider shall provide the commissioner information
 468.25 to verify the provider's annual revenues or other information as needed, including copies
 468.26 of documents submitted to the Department of Revenue.

468.27 (e) At each annual renewal, a home care provider may elect to pay the highest
 468.28 renewal fee for its license category, and not provide annual revenue information to the
 468.29 commissioner.

468.30 (f) A temporary license or license applicant, or temporary licensee or licensee that
 468.31 knowingly provides the commissioner incorrect revenue amounts for the purpose of
 468.32 paying a lower license fee shall be subject to a civil penalty in the amount of double the
 468.33 fee the provider should have paid.

468.34 (g) Fees and penalties collected under this section shall be deposited in the state
 468.35 treasury and credited to the special state government revenue fund.

468.36 (h) The license renewal fee schedule in this subdivision is effective July 1, 2016.

468.37 **Sec. 12. [144A.473] ISSUANCE OF TEMPORARY LICENSE AND LICENSE**
 468.38 **RENEWAL.**

468.39 **Subdivision 1. Temporary license and renewal of license.** (a) The department
 468.40 shall review each application to determine the applicant's knowledge of and compliance
 468.41 with Minnesota home care regulations. Before granting a temporary license or renewing a

469.1 license, the commissioner may further evaluate the applicant or licensee by requesting
469.2 additional information or documentation or by conducting an on-site survey of the
469.3 applicant to determine compliance with sections 144A.43 to 144A.482.

469.4 (b) Within 14 calendar days after receiving an application for a license,
469.5 the commissioner shall acknowledge receipt of the application in writing. The
469.6 acknowledgment must indicate whether the application appears to be complete or whether
469.7 additional information is required before the application will be considered complete.

469.8 (c) Within 90 days after receiving a complete application, the commissioner shall
469.9 issue a temporary license, renew the license, or deny the license.

469.10 (d) The commissioner shall issue a license that contains the home care provider's
469.11 name, address, license level, expiration date of the license, and unique license number. All
469.12 licenses are valid for one year from the date of issuance.

469.13 Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner
469.14 shall issue a temporary license for either the basic or comprehensive home care level. A
469.15 temporary license is effective for one year from the date of issuance. Temporary licensees
469.16 must comply with sections 144A.43 to 144A.482.

469.17 (b) During the temporary license year, the commissioner shall survey the temporary
469.18 licensee after the commissioner is notified or has evidence that the temporary licensee
469.19 is providing home care services.

469.20 (c) Within five days of beginning the provision of services, the temporary
469.21 licensee must notify the commissioner that it is serving clients. The notification to the
469.22 commissioner may be mailed or e-mailed to the commissioner at the address provided by
469.23 the commissioner. If the temporary licensee does not provide home care services during
469.24 the temporary license year, then the temporary license expires at the end of the year and
469.25 the applicant must reapply for a temporary home care license.

469.26 (d) A temporary licensee may request a change in the level of licensure prior to
469.27 being surveyed and granted a license by notifying the commissioner in writing and
469.28 providing additional documentation or materials required to update or complete the
469.29 changed temporary license application. The applicant must pay the difference between
469.30 the application fees when changing from the basic level to the comprehensive level of
469.31 licensure. No refund will be made if the provider chooses to change the license application
469.32 to the basic level.

469.33 (e) If the temporary licensee notifies the commissioner that the licensee has clients
469.34 within 45 days prior to the temporary license expiration, the commissioner may extend the
469.35 temporary license for up to 60 days in order to allow the commissioner to complete the
469.36 on-site survey required under this section and follow-up survey visits.

470.1 Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial
470.2 compliance with the survey, the commissioner shall issue either a basic or comprehensive
470.3 home care license. If the temporary licensee is not in substantial compliance with the
470.4 survey, the commissioner shall not issue a basic or comprehensive license and there will
470.5 be no contested hearing right under chapter 14.

470.6 (b) If the temporary licensee whose basic or comprehensive license has been denied
470.7 disagrees with the conclusions of the commissioner, then the licensee may request a
470.8 reconsideration by the commissioner or commissioner's designee. The reconsideration
470.9 request process must be conducted internally by the commissioner or commissioner's
470.10 designee, and chapter 14 does not apply.

470.11 (c) The temporary licensee requesting reconsideration must make the request in
470.12 writing and must list and describe the reasons why the licensee disagrees with the decision
470.13 to deny the basic or comprehensive home care license.

470.14 (d) A temporary licensee whose license is denied must comply with the requirements
470.15 for notification and transfer of clients in section 144A.475, subdivision 5.

470.16 **Sec. 13. [144A.474] SURVEYS AND INVESTIGATIONS.**

470.17 Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home
470.18 care provider. By June 30, 2016, the commissioner shall conduct a survey of home care
470.19 providers on a frequency of at least once every three years. Survey frequency may be
470.20 based on the license level, the provider's compliance history, number of clients served,
470.21 or other factors as determined by the department deemed necessary to ensure the health,
470.22 safety, and welfare of clients and compliance with the law.

470.23 Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of
470.24 a new temporary licensee conducted after the department is notified or has evidence that
470.25 the temporary licensee is providing home care services to determine if the provider is in
470.26 compliance with home care requirements. Initial full surveys must be completed within 14
470.27 months after the department's issuance of a temporary basic or comprehensive license.

470.28 (b) "Core survey" means periodic inspection of home care providers to determine
470.29 ongoing compliance with the home care requirements, focusing on the essential health and
470.30 safety requirements. Core surveys are available to licensed home care providers who have
470.31 been licensed for three years and surveyed at least once in the past three years with the
470.32 latest survey having no widespread violations beyond Level 1 as provided in subdivision
470.33 11. Providers must also not have had any substantiated licensing complaints, substantiated
470.34 complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors
470.35 Act, or an enforcement action as authorized in section 144A.475 in the past three years.

471.1 (1) The core survey for basic home care providers must review compliance in the
471.2 following areas:

471.3 (i) reporting of maltreatment;

471.4 (ii) orientation to and implementation of Home Care Client Bill of Rights;

471.5 (iii) statement of home care services;

471.6 (iv) initial evaluation of clients and initiation of services;

471.7 (v) client review and monitoring;

471.8 (vi) service plan implementation and changes to the service plan;

471.9 (vii) client complaint and investigative process;

471.10 (viii) competency of unlicensed personnel; and

471.11 (ix) infection control.

471.12 (2) For comprehensive home care providers, the core survey must include everything
471.13 in the basic core survey plus these areas:

471.14 (i) delegation to unlicensed personnel;

471.15 (ii) assessment, monitoring, and reassessment of clients; and

471.16 (iii) medication, treatment, and therapy management.

471.17 (c) "Full survey" means the periodic inspection of home care providers to determine
471.18 ongoing compliance with the home care requirements that cover the core survey areas
471.19 and all the legal requirements for home care providers. A full survey is conducted for all
471.20 temporary licensees and for providers who do not meet the requirements needed for a core
471.21 survey, and when a surveyor identifies unacceptable client health or safety risks during a
471.22 core survey. A full survey must include all the tasks identified as part of the core survey
471.23 and any additional review deemed necessary by the department, including additional
471.24 observation, interviewing, or records review of additional clients and staff.

471.25 (d) "Follow-up surveys" means surveys conducted to determine if a home care
471.26 provider has corrected deficient issues and systems identified during a core survey, full
471.27 survey, or complaint investigation. Follow-up surveys may be conducted via phone,
471.28 e-mail, fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys,
471.29 shall be concluded with an exit conference and written information provided on the
471.30 process for requesting a reconsideration of the survey results.

471.31 (e) Upon receiving information alleging that a home care provider has violated or
471.32 is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner
471.33 shall investigate the complaint according to sections 144A.51 to 144A.54.

471.34 Subd. 3. **Survey process.** (a) The survey process for core surveys shall include the
471.35 following as applicable to the particular licensee and setting surveyed:

- 472.1 (1) presurvey review of pertinent documents and notification to the ombudsman
472.2 for long-term care;
- 472.3 (2) an entrance conference with available staff;
- 472.4 (3) communication with managerial officials or the registered nurse in charge, if
472.5 available, and ongoing communication with key staff throughout the survey regarding
472.6 information needed by the surveyor, clarifications regarding home care requirements, and
472.7 applicable standards of practice;
- 472.8 (4) presentation of written contact information to the provider about the survey staff
472.9 conducting the survey, the supervisor, and the process for requesting a reconsideration of
472.10 the survey results;
- 472.11 (5) a brief tour of a sample of the housing with services establishments in which the
472.12 provider is providing home care services;
- 472.13 (6) a sample selection of home care clients;
- 472.14 (7) information-gathering through client and staff observations, client and staff
472.15 interviews, and reviews of records, policies, procedures, practices, and other agency
472.16 information;
- 472.17 (8) interviews of clients' family members, if available, with clients' consent when the
472.18 client can legally give consent;
- 472.19 (9) except for complaint surveys conducted by the Office of Health Facilities
472.20 Complaints, an on-site exit conference, with preliminary findings shared and discussed
472.21 with the provider, documentation that an exit conference occurred, and written information
472.22 provided on the process for requesting a reconsideration of the survey results; and
- 472.23 (10) postsurvey analysis of findings and formulation of survey results, including
472.24 correction orders when applicable.
- 472.25 Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted
472.26 without advance notice to home care providers. Surveyors may contact the home care
472.27 provider on the day of a survey to arrange for someone to be available at the survey site.
472.28 The contact does not constitute advance notice.
- 472.29 Subd. 5. **Information provided by home care provider.** The home care provider
472.30 shall provide accurate and truthful information to the department during a survey,
472.31 investigation, or other licensing activities.
- 472.32 Subd. 6. **Providing client records.** Upon request of a surveyor, home care providers
472.33 shall provide a list of current and past clients or client representatives that includes
472.34 addresses and telephone numbers and any other information requested about the services
472.35 to clients within a reasonable period of time.

473.1 Subd. 7. **Contacting and visiting clients.** Surveyors may contact or visit a home
473.2 care provider's clients to gather information without notice to the home care provider.
473.3 Before visiting a client, a surveyor shall obtain the client's or client's representative's
473.4 permission by telephone, mail, or in person. Surveyors shall inform all clients or client's
473.5 representatives of their right to decline permission for a visit.

473.6 Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the
473.7 commissioner finds upon survey or during a complaint investigation that a home care
473.8 provider, a managerial official, or an employee of the provider is not in compliance with
473.9 sections 144A.43 to 144A.482. The correction order shall cite the specific statute and
473.10 document areas of noncompliance and the time allowed for correction.

473.11 (b) The commissioner shall mail copies of any correction order within 30 calendar
473.12 days after an exit survey to the last known address of the home care provider. A copy of
473.13 each correction order and copies of any documentation supplied to the commissioner shall
473.14 be kept on file by the home care provider, and public documents shall be made available
473.15 for viewing by any person upon request. Copies may be kept electronically.

473.16 (c) By the correction order date, the home care provider must document in the
473.17 provider's records any action taken to comply with the correction order. The commissioner
473.18 may request a copy of this documentation and the home care provider's action to respond
473.19 to the correction order in future surveys, upon a complaint investigation, and as otherwise
473.20 needed.

473.21 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations,
473.22 under subdivision 11, or any violations determined to be widespread, the department shall
473.23 conduct a follow-up survey within 90 calendar days of the survey. When conducting a
473.24 follow-up survey, the surveyor will focus on whether the previous violations have been
473.25 corrected and may also address any new violations that are observed while evaluating the
473.26 corrections that have been made. If a new violation is identified on a follow-up survey, no
473.27 fine will be imposed unless it is not corrected on the next follow-up survey.

473.28 Subd. 10. **Performance incentive.** A licensee is eligible for a performance
473.29 incentive if there are no violations identified in a core or full survey. The performance
473.30 incentive is a ten percent discount on the licensee's next home care renewal license fee.

473.31 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be
473.32 assessed based on the level and scope of the violations described in paragraph (c) as follows:

473.33 (1) Level 1, no fines or enforcement;

473.34 (2) Level 2, fines ranging from \$0 to \$500, in addition to any of the enforcement
473.35 mechanisms authorized in section 144A.475 for widespread violations;

474.1 (3) Level 3, fines ranging from \$500 to \$1,000, in addition to any of the enforcement
474.2 mechanisms authorized in section 144A.475; and

474.3 (4) Level 4, fines ranging from \$1,000 to \$5,000, in addition to any of the
474.4 enforcement mechanisms authorized in section 144A.475.

474.5 (b) Correction orders for violations are categorized by both level and scope and
474.6 fines shall be assessed as follows:

474.7 (1) Level of violation:

474.8 (i) Level 1 is a violation that has no potential to cause more than a minimal impact
474.9 on the client and does not affect health or safety;

474.10 (ii) Level 2 is a violation that did not harm a client's health or safety but had the
474.11 potential to have harmed a client's health or safety, but was not likely to cause serious
474.12 injury, impairment, or death;

474.13 (iii) Level 3 is a violation that harmed a client's health or safety, not including
474.14 serious injury, impairment, or death, or a violation that has the potential to lead to serious
474.15 injury, impairment, or death; and

474.16 (iv) Level 4 is a violation that results in serious injury, impairment, or death.

474.17 (2) Scope of violation:

474.18 (i) isolated, when one or a limited number of clients are affected or one or a limited
474.19 number of staff are involved or the situation has occurred only occasionally;

474.20 (ii) pattern, when more than a limited number of clients are affected, more than a
474.21 limited number of staff are involved, or the situation has occurred repeatedly but is not
474.22 found to be pervasive; and

474.23 (iii) widespread, when problems are pervasive or represent a systemic failure that
474.24 has affected or has the potential to affect a large portion or all of the clients.

474.25 (c) If the commissioner finds that the applicant or a home care provider required
474.26 to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the
474.27 date specified in the correction order or conditional license resulting from a survey or
474.28 complaint investigation, the commissioner may impose a fine. A notice of noncompliance
474.29 with a correction order must be mailed to the applicant's or provider's last known address.
474.30 The noncompliance notice must list the violations not corrected.

474.31 (d) The license holder must pay the fines assessed on or before the payment date
474.32 specified. If the license holder fails to fully comply with the order, the commissioner
474.33 may issue a second fine or suspend the license until the license holder complies by
474.34 paying the fine. A timely appeal shall stay payment of the fine until the commissioner
474.35 issues a final order.

475.1 (e) A license holder shall promptly notify the commissioner in writing when a
475.2 violation specified in the order is corrected. If upon reinspection the commissioner
475.3 determines that a violation has not been corrected as indicated by the order, the
475.4 commissioner may issue a second fine. The commissioner shall notify the license holder by
475.5 mail to the last known address in the licensing record that a second fine has been assessed.
475.6 The license holder may appeal the second fine as provided under this subdivision.

475.7 (f) A home care provider that has been assessed a fine under this subdivision has a
475.8 right to a reconsideration or a hearing under this section and chapter 14.

475.9 (g) When a fine has been assessed, the license holder may not avoid payment by
475.10 closing, selling, or otherwise transferring the licensed program to a third party. In such an
475.11 event, the license holder shall be liable for payment of the fine.

475.12 (h) In addition to any fine imposed under this section, the commissioner may assess
475.13 costs related to an investigation that results in a final order assessing a fine or other
475.14 enforcement action authorized by this chapter.

475.15 (i) Fines collected under this subdivision shall be deposited in the state government
475.16 special revenue fund and credited to an account separate from the revenue collected under
475.17 section 144A.472. Subject to an appropriation by the legislature, the revenue from the
475.18 finances collected may be used by the commissioner for special projects to improve home care
475.19 in Minnesota as recommended by the advisory council established in section 144A.4799.

475.20 Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home
475.21 care providers a correction order reconsideration process. This process may be used
475.22 to challenge the correction order issued, including the level and scope described in
475.23 subdivision 11, and any fine assessed. During the correction order reconsideration
475.24 request, the issuance for the correction orders under reconsideration are not stayed, but
475.25 the department shall post information on the Web site with the correction order that the
475.26 licensee has requested a reconsideration and that the review is pending.

475.27 (b) A licensed home care provider may request from the commissioner, in writing,
475.28 a correction order reconsideration regarding any correction order issued to the provider.
475.29 The correction order reconsideration shall not be reviewed by any surveyor, investigator,
475.30 or supervisor that participated in the writing or reviewing of the correction order
475.31 being disputed. The correction order reconsiderations may be conducted in person, by
475.32 telephone, by another electronic form, or in writing, as determined by the commissioner.
475.33 The commissioner shall respond in writing to the request from a home care provider
475.34 for a correction order reconsideration within 60 days of the date the provider requests a
475.35 reconsideration. The commissioner's response shall identify the commissioner's decision
475.36 regarding each citation challenged by the home care provider.

476.1 (c) The findings of a correction order reconsideration process shall be one or more of
476.2 the following:

476.3 (1) supported in full, the correction order is supported in full, with no deletion of
476.4 findings to the citation;

476.5 (2) supported in substance, the correction order is supported, but one or more
476.6 findings are deleted or modified without any change in the citation;

476.7 (3) correction order cited an incorrect home care licensing requirement, the correction
476.8 order is amended by changing the correction order to the appropriate statutory reference;

476.9 (4) correction order was issued under an incorrect citation, the correction order is
476.10 amended to be issued under the more appropriate correction order citation;

476.11 (5) the correction order is rescinded;

476.12 (6) fine is amended, it is determined that the fine assigned to the correction order
476.13 was applied incorrectly; or

476.14 (7) the level or scope of the citation is modified based on the reconsideration.

476.15 (d) If the correction order findings are changed by the commissioner, the
476.16 commissioner shall update the correction order Web site.

476.17 Subd. 13. **Home care surveyor training.** (a) Before conducting a home care
476.18 survey, each home care surveyor must receive training on the following topics:

476.19 (1) Minnesota home care licensure requirements;

476.20 (2) Minnesota Home Care Client Bill of Rights;

476.21 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

476.22 (4) principles of documentation;

476.23 (5) survey protocol and processes;

476.24 (6) Offices of the Ombudsman roles;

476.25 (7) Office of Health Facility Complaints;

476.26 (8) Minnesota landlord-tenant and housing with services laws;

476.27 (9) types of payors for home care services; and

476.28 (10) Minnesota Nurse Practice Act for nurse surveyors.

476.29 (b) Materials used for the training in paragraph (a) shall be posted on the department
476.30 Web site. Requisite understanding of these topics will be reviewed as part of the quality
476.31 improvement plan in section 144A.483.

476.32 Sec. 14. **[144A.475] ENFORCEMENT.**

476.33 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary
476.34 license, renew a license, suspend or revoke a license, or impose a conditional license if the
476.35 home care provider or owner or managerial official of the home care provider:

- 477.1 (1) is in violation of, or during the term of the license has violated, any of the
477.2 requirements in sections 144A.471 to 144A.482;
- 477.3 (2) permits, aids, or abets the commission of any illegal act in the provision of
477.4 home care;
- 477.5 (3) performs any act detrimental to the health, safety, and welfare of a client;
- 477.6 (4) obtains the license by fraud or misrepresentation;
- 477.7 (5) knowingly made or makes a false statement of a material fact in the application
477.8 for a license or in any other record or report required by this chapter;
- 477.9 (6) denies representatives of the department access to any part of the home care
477.10 provider's books, records, files, or employees;
- 477.11 (7) interferes with or impedes a representative of the department in contacting the
477.12 home care provider's clients;
- 477.13 (8) interferes with or impedes a representative of the department in the enforcement
477.14 of this chapter or has failed to fully cooperate with an inspection, survey, or investigation
477.15 by the department;
- 477.16 (9) destroys or makes unavailable any records or other evidence relating to the home
477.17 care provider's compliance with this chapter;
- 477.18 (10) refuses to initiate a background study under section 144.057 or 245A.04;
- 477.19 (11) fails to timely pay any fines assessed by the department;
- 477.20 (12) violates any local, city, or township ordinance relating to home care services;
- 477.21 (13) has repeated incidents of personnel performing services beyond their
477.22 competency level; or
- 477.23 (14) has operated beyond the scope of the home care provider's license level.
- 477.24 (b) A violation by a contractor providing the home care services of the home care
477.25 provider is a violation by the home care provider.
- 477.26 Subd. 2. **Terms to suspension or conditional license.** A suspension or conditional
477.27 license designation may include terms that must be completed or met before a suspension
477.28 or conditional license designation is lifted. A conditional license designation may include
477.29 restrictions or conditions that are imposed on the provider. Terms for a suspension or
477.30 conditional license may include one or more of the following and the scope of each will be
477.31 determined by the commissioner:
- 477.32 (1) requiring a consultant to review, evaluate, and make recommended changes to
477.33 the home care provider's practices and submit reports to the commissioner at the cost of
477.34 the home care provider;

478.1 (2) requiring supervision of the home care provider or staff practices at the cost
478.2 of the home care provider by an unrelated person who has sufficient knowledge and
478.3 qualifications to oversee the practices and who will submit reports to the commissioner;

478.4 (3) requiring the home care provider or employees to obtain training at the cost of
478.5 the home care provider;

478.6 (4) requiring the home care provider to submit reports to the commissioner;

478.7 (5) prohibiting the home care provider from taking any new clients for a period
478.8 of time; or

478.9 (6) any other action reasonably required to accomplish the purpose of this
478.10 subdivision and section 144A.45, subdivision 2.

478.11 Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license,
478.12 the home care provider shall be entitled to notice and a hearing as provided by sections
478.13 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may,
478.14 without a prior contested case hearing, temporarily suspend a license or prohibit delivery
478.15 of services by a provider for not more than 90 days if the commissioner determines that
478.16 the health or safety of a consumer is in imminent danger, provided:

478.17 (1) advance notice is given to the home care provider;

478.18 (2) after notice, the home care provider fails to correct the problem;

478.19 (3) the commissioner has reason to believe that other administrative remedies are not
478.20 likely to be effective; and

478.21 (4) there is an opportunity for a contested case hearing within the 90 days.

478.22 Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties
478.23 under section 144A.45, subdivision 2, clause (5), and an action against a license under
478.24 this section, a provider must request a hearing no later than 15 days after the provider
478.25 receives notice of the action.

478.26 Subd. 5. **Plan required.** (a) The process of suspending or revoking a license
478.27 must include a plan for transferring affected clients to other providers by the home care
478.28 provider, which will be monitored by the commissioner. Within three business days of
478.29 being notified of the final revocation or suspension action, the home care provider shall
478.30 provide the commissioner, the lead agencies as defined in section 256B.0911, and the
478.31 ombudsman for long-term care with the following information:

478.32 (1) a list of all clients, including full names and all contact information on file;

478.33 (2) a list of each client's representative or emergency contact person, including full
478.34 names and all contact information on file;

478.35 (3) the location or current residence of each client;

479.1 (4) the payor sources for each client, including payor source identification numbers;
479.2 and

479.3 (5) for each client, a copy of the client's service plan, and a list of the types of
479.4 services being provided.

479.5 (b) The revocation or suspension notification requirement is satisfied by mailing the
479.6 notice to the address in the license record. The home care provider shall cooperate with
479.7 the commissioner and the lead agencies during the process of transferring care of clients to
479.8 qualified providers. Within three business days of being notified of the final revocation or
479.9 suspension action, the home care provider must notify and disclose to each of the home
479.10 care provider's clients, or the client's representative or emergency contact persons, that
479.11 the commissioner is taking action against the home care provider's license by providing a
479.12 copy of the revocation or suspension notice issued by the commissioner.

479.13 Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The
479.14 owner and managerial officials of a home care provider whose Minnesota license has not
479.15 been renewed or that has been revoked because of noncompliance with applicable laws or
479.16 rules shall not be eligible to apply for nor will be granted a home care license, including
479.17 other licenses under this chapter, or be given status as an enrolled personal care assistance
479.18 provider agency or personal care assistant by the Department of Human Services under
479.19 section 256B.0659 for five years following the effective date of the nonrenewal or
479.20 revocation. If the owner and managerial officials already have enrollment status, their
479.21 enrollment will be terminated by the Department of Human Services.

479.22 (b) The commissioner shall not issue a license to a home care provider for five
479.23 years following the effective date of license nonrenewal or revocation if the owner or
479.24 managerial official, including any individual who was an owner or managerial official
479.25 of another home care provider, had a Minnesota license that was not renewed or was
479.26 revoked as described in paragraph (a).

479.27 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall
479.28 suspend or revoke, the license of any home care provider that includes any individual
479.29 as an owner or managerial official who was an owner or managerial official of a home
479.30 care provider whose Minnesota license was not renewed or was revoked as described in
479.31 paragraph (a) for five years following the effective date of the nonrenewal or revocation.

479.32 (d) The commissioner shall notify the home care provider 30 days in advance of
479.33 the date of nonrenewal, suspension, or revocation of the license. Within ten days after
479.34 the receipt of the notification, the home care provider may request, in writing, that the
479.35 commissioner stay the nonrenewal, revocation, or suspension of the license. The home
479.36 care provider shall specify the reasons for requesting the stay; the steps that will be taken

480.1 to attain or maintain compliance with the licensure laws and regulations; any limits on the
480.2 authority or responsibility of the owners or managerial officials whose actions resulted in
480.3 the notice of nonrenewal, revocation, or suspension; and any other information to establish
480.4 that the continuing affiliation with these individuals will not jeopardize client health, safety,
480.5 or well-being. The commissioner shall determine whether the stay will be granted within
480.6 30 days of receiving the provider's request. The commissioner may propose additional
480.7 restrictions or limitations on the provider's license and require that the granting of the stay
480.8 be contingent upon compliance with those provisions. The commissioner shall take into
480.9 consideration the following factors when determining whether the stay should be granted:

480.10 (1) the threat that continued involvement of the owners and managerial officials with
480.11 the home care provider poses to client health, safety, and well-being;

480.12 (2) the compliance history of the home care provider; and

480.13 (3) the appropriateness of any limits suggested by the home care provider.

480.14 If the commissioner grants the stay, the order shall include any restrictions or
480.15 limitation on the provider's license. The failure of the provider to comply with any
480.16 restrictions or limitations shall result in the immediate removal of the stay and the
480.17 commissioner shall take immediate action to suspend, revoke, or not renew the license.

480.18 Subd. 7. **Request for hearing.** A request for a hearing must be in writing and must:

480.19 (1) be mailed or delivered to the department or the commissioner's designee;

480.20 (2) contain a brief and plain statement describing every matter or issue contested; and

480.21 (3) contain a brief and plain statement of any new matter that the applicant or home
480.22 care provider believes constitutes a defense or mitigating factor.

480.23 Subd. 8. **Informal conference.** At any time, the applicant or home care provider
480.24 and the commissioner may hold an informal conference to exchange information, clarify
480.25 issues, or resolve issues.

480.26 Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the
480.27 commissioner may bring an action in district court to enjoin a person who is involved in
480.28 the management, operation, or control of a home care provider or an employee of the
480.29 home care provider from illegally engaging in activities regulated by sections 144A.43 to
480.30 144A.482. The commissioner may bring an action under this subdivision in the district
480.31 court in Ramsey County or in the district in which a home care provider is providing
480.32 services. The court may grant a temporary restraining order in the proceeding if continued
480.33 activity by the person who is involved in the management, operation, or control of a home
480.34 care provider, or by an employee of the home care provider, would create an imminent
480.35 risk of harm to a recipient of home care services.

481.1 Subd. 10. **Subpoena.** In matters pending before the commissioner under sections
481.2 144A.43 to 144A.482, the commissioner may issue subpoenas and compel the attendance
481.3 of witnesses and the production of all necessary papers, books, records, documents, and
481.4 other evidentiary material. If a person fails or refuses to comply with a subpoena or
481.5 order of the commissioner to appear or testify regarding any matter about which the
481.6 person may be lawfully questioned or to produce any papers, books, records, documents,
481.7 or evidentiary materials in the matter to be heard, the commissioner may apply to the
481.8 district court in any district, and the court shall order the person to comply with the
481.9 commissioner's order or subpoena. The commissioner of health may administer oaths to
481.10 witnesses or take their affirmation. Depositions may be taken in or outside the state in the
481.11 manner provided by law for the taking of depositions in civil actions. A subpoena or other
481.12 process or paper may be served on a named person anywhere in the state by an officer
481.13 authorized to serve subpoenas in civil actions, with the same fees and mileage and in the
481.14 same manner as prescribed by law for a process issued out of a district court. A person
481.15 subpoenaed under this subdivision shall receive the same fees, mileage, and other costs
481.16 that are paid in proceedings in district court.

481.17 Sec. 15. **[144A.476] BACKGROUND STUDIES.**

481.18 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a)
481.19 Before the commissioner issues a temporary license or renews a license, an owner or
481.20 managerial official is required to complete a background study under section 144.057. No
481.21 person may be involved in the management, operation, or control of a home care provider
481.22 if the person has been disqualified under chapter 245C. If an individual is disqualified
481.23 under section 144.057 or chapter 245C, the individual may request reconsideration of
481.24 the disqualification. If the individual requests reconsideration and the commissioner
481.25 sets aside or rescinds the disqualification, the individual is eligible to be involved in the
481.26 management, operation, or control of the provider. If an individual has a disqualification
481.27 under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's
481.28 disqualification is barred from a set aside, and the individual must not be involved in the
481.29 management, operation, or control of the provider.

481.30 (b) For purposes of this section, owners of a home care provider subject to the
481.31 background check requirement are those individuals whose ownership interest provides
481.32 sufficient authority or control to affect or change decisions related to the operation of the
481.33 home care provider. An owner includes a sole proprietor, a general partner, or any other
481.34 individual whose individual ownership interest can affect the management and direction
481.35 of the policies of the home care provider.

482.1 (c) For the purposes of this section, managerial officials subject to the background
482.2 check requirement are individuals who provide direct contact as defined in section
482.3 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing
482.4 management or direction of the policies, services, or employees of the home care provider.
482.5 Data collected under this subdivision shall be classified as private data on individuals
482.6 under section 13.02, subdivision 12.

482.7 (d) The department shall not issue any license if the applicant or owner or managerial
482.8 official has been unsuccessful in having a background study disqualification set aside
482.9 under section 144.057 and chapter 245C; if the owner or managerial official, as an owner
482.10 or managerial official of another home care provider, was substantially responsible for
482.11 the other home care provider's failure to substantially comply with sections 144A.43 to
482.12 144A.482; or if an owner that has ceased doing business, either individually or as an
482.13 owner of a home care provider, was issued a correction order for failing to assist clients in
482.14 violation of this chapter.

482.15 Subd. 2. **Employees, contractors, and volunteers.** (a) Employees, contractors,
482.16 and volunteers of a home care provider are subject to the background study required by
482.17 section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall
482.18 be construed to prohibit a home care provider from requiring self-disclosure of criminal
482.19 conviction information.

482.20 (b) Termination of an employee in good faith reliance on information or records
482.21 obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not
482.22 subject the home care provider to civil liability or liability for unemployment benefits.

482.23 Sec. 16. **[144A.477] COMPLIANCE.**

482.24 Subdivision 1. **Medicare-certified providers; coordination of surveys.** If feasible,
482.25 the commissioner shall survey licensees to determine compliance with this chapter at the
482.26 same time as surveys for certification for Medicare if Medicare certification is based on
482.27 compliance with the federal conditions of participation and on survey and enforcement
482.28 by the Department of Health as agent for the United States Department of Health and
482.29 Human Services.

482.30 Subd. 2. **Medicare-certified providers; equivalent requirements.** For home care
482.31 providers licensed to provide comprehensive home care services that are also certified for
482.32 participation in Medicare as a home health agency under Code of Federal Regulations,
482.33 title 42, part 484, the following state licensure regulations are considered equivalent to
482.34 the federal requirements:

482.35 (1) quality management, section 144A.479, subdivision 3;

- 483.1 (2) personnel records, section 144A.479, subdivision 7;
483.2 (3) acceptance of clients, section 144A.4791, subdivision 4;
483.3 (4) referrals, section 144A.4791, subdivision 5;
483.4 (5) client assessment, sections 144A.4791, subdivision 8, and 144A.4792,
483.5 subdivisions 2 and 3;
483.6 (6) individualized monitoring and reassessment, sections 144A.4791, subdivision
483.7 8, and 144A.4792, subdivisions 2 and 3;
483.8 (7) individualized service plan, sections 144A.4791, subdivision 9, 144A.4792,
483.9 subdivision 5, and 144A.4793, subdivision 3;
483.10 (8) client complaint and investigation process, section 144A.4791, subdivision 11;
483.11 (9) prescription orders, section 144A.4792, subdivisions 13 to 16;
483.12 (10) client records, section 144A.4794, subdivisions 1 to 3;
483.13 (11) qualifications for unlicensed personnel performing delegated tasks, section
483.14 144A.4795;
483.15 (12) training and competency staff, section 144A.4795;
483.16 (13) training and competency for unlicensed personnel, section 144A.4795,
483.17 subdivision 7;
483.18 (14) delegation of home care services, section 144A.4795, subdivision 4;
483.19 (15) availability of contact person, section 144A.4797, subdivision 1; and
483.20 (16) supervision of staff, section 144A.4797, subdivisions 2 and 3.
483.21 Violations of requirements in clauses (1) to (16) may lead to enforcement actions
483.22 under section 144A.474.

483.23 **Sec. 17. [144A.478] INNOVATION VARIANCE.**

483.24 Subdivision 1. **Definition.** For purposes of this section, "innovation variance"
483.25 means a specified alternative to a requirement of this chapter. An innovation variance
483.26 may be granted to allow a home care provider to offer home care services of a type or
483.27 in a manner that is innovative, will not impair the services provided, will not adversely
483.28 affect the health, safety, or welfare of the clients, and is likely to improve the services
483.29 provided. The innovative variance cannot change any of the client's rights under section
483.30 144A.44, home care bill of rights.

483.31 Subd. 2. **Conditions.** The commissioner may impose conditions on the granting of
483.32 an innovation variance that the commissioner considers necessary.

483.33 Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any
483.34 innovation variance and may renew a limited innovation variance.

484.1 Subd. 4. **Applications; innovation variance.** An application for innovation
484.2 variance from the requirements of this chapter may be made at any time, must be made in
484.3 writing to the commissioner, and must specify the following:

- 484.4 (1) the statute or law from which the innovation variance is requested;
484.5 (2) the time period for which the innovation variance is requested;
484.6 (3) the specific alternative action that the licensee proposes;
484.7 (4) the reasons for the request; and
484.8 (5) justification that an innovation variance will not impair the services provided,
484.9 will not adversely affect the health, safety, or welfare of clients, and is likely to improve
484.10 the services provided.

484.11 The commissioner may require additional information from the home care provider before
484.12 acting on the request.

484.13 Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request
484.14 for an innovation variance in writing within 45 days of receipt of a complete request.
484.15 Notice of a denial shall contain the reasons for the denial. The terms of a requested
484.16 innovation variance may be modified upon agreement between the commissioner and
484.17 the home care provider.

484.18 Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of
484.19 an innovation variance shall be deemed to be a violation of this chapter.

484.20 Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or
484.21 deny renewal of an innovation variance if:

- 484.22 (1) it is determined that the innovation variance is adversely affecting the health,
484.23 safety, or welfare of the licensee's clients;
484.24 (2) the home care provider has failed to comply with the terms of the innovation
484.25 variance;
484.26 (3) the home care provider notifies the commissioner in writing that it wishes to
484.27 relinquish the innovation variance and be subject to the statute previously varied; or
484.28 (4) the revocation or denial is required by a change in law.

484.29 Sec. 18. **[144A.479] HOME CARE PROVIDER RESPONSIBILITIES;**
484.30 **BUSINESS OPERATION.**

484.31 Subdivision 1. **Display of license.** The original current license must be displayed
484.32 in the home care providers' principal business office and copies must be displayed in
484.33 any branch office. The home care provider must provide a copy of the license to any
484.34 person who requests it.

485.1 Subd. 2. **Advertising.** Home care providers shall not use false, fraudulent,
485.2 or misleading advertising in the marketing of services. For purposes of this section,
485.3 advertising includes any verbal, written, or electronic means of communicating to
485.4 potential clients about the availability, nature, or terms of home care services.

485.5 Subd. 3. **Quality management.** The home care provider shall engage in quality
485.6 management appropriate to the size of the home care provider and relevant to the type
485.7 of services the home care provider provides. The quality management activity means
485.8 evaluating the quality of care by periodically reviewing client services, complaints made,
485.9 and other issues that have occurred and determining whether changes in services, staffing,
485.10 or other procedures need to be made in order to ensure safe and competent services to
485.11 clients. Documentation about quality management activity must be available for two
485.12 years. Information about quality management must be available to the commissioner at
485.13 the time of the survey, investigation, or renewal.

485.14 Subd. 4. **Provider restrictions.** (a) This subdivision does not apply to licensees
485.15 that are Minnesota counties or other units of government.

485.16 (b) A home care provider or staff cannot accept powers-of-attorney from clients for
485.17 any purpose, and may not accept appointments as guardians or conservators of clients.

485.18 (c) A home care provider cannot serve as a client's representative.

485.19 Subd. 5. **Handling of client's finances and property.** (a) A home care provider
485.20 may assist clients with household budgeting, including paying bills and purchasing
485.21 household goods, but may not otherwise manage a client's property. A home care provider
485.22 must provide a client with receipts for all transactions and purchases paid with the client's
485.23 funds. When receipts are not available, the transaction or purchase must be documented.
485.24 A home care provider must maintain records of all such transactions.

485.25 (b) A home care provider or staff may not borrow a client's funds or personal or
485.26 real property, nor in any way convert a client's property to the home care provider's or
485.27 staff's possession.

485.28 (c) Nothing in this section precludes a home care provider or staff from accepting
485.29 gifts of minimal value, or precludes the acceptance of donations or bequests made to a
485.30 home care provider that are exempt from income tax under section 501(c) of the Internal
485.31 Revenue Code of 1986.

485.32 Subd. 6. **Reporting maltreatment of vulnerable adults and minors.** (a) All home
485.33 care providers must comply with requirements for the reporting of maltreatment of minors
485.34 in section 626.556 and the requirements for the reporting of maltreatment of vulnerable
485.35 adults in section 626.557. Each home care provider must establish and implement a
485.36 written procedure to ensure that all cases of suspected maltreatment are reported.

486.1 (b) Each home care provider must develop and implement an individual abuse
486.2 prevention plan for each vulnerable minor or adult for whom home care services are
486.3 provided by a home care provider. The plan shall contain an individualized review or
486.4 assessment of the person's susceptibility to abuse by another individual, including other
486.5 vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors;
486.6 and statements of the specific measures to be taken to minimize the risk of abuse to that
486.7 person and other vulnerable adults or minors. For purposes of the abuse prevention plan,
486.8 the term abuse includes self-abuse.

486.9 Subd. 7. **Employee records.** The home care provider must maintain current records
486.10 of each paid employee, regularly scheduled volunteers providing home care services, and
486.11 of each individual contractor providing home care services. The records must include
486.12 the following information:

486.13 (1) evidence of current professional licensure, registration, or certification, if
486.14 licensure, registration, or certification is required by this statute, or other rules;

486.15 (2) records of orientation, required annual training and infection control training,
486.16 and competency evaluations;

486.17 (3) current job description, including qualifications, responsibilities, and
486.18 identification of staff providing supervision;

486.19 (4) documentation of annual performance reviews which identify areas of
486.20 improvement needed and training needs;

486.21 (5) for individuals providing home care services, verification that required health
486.22 screenings under section 144A.4798 have taken place and the dates of those screenings; and

486.23 (6) documentation of the background study as required under section 144.057.

486.24 Each employee record must be retained for at least three years after a paid employee,
486.25 home care volunteer, or contractor ceases to be employed by or under contract with the
486.26 home care provider. If a home care provider ceases operation, employee records must be
486.27 maintained for three years.

486.28 Sec. 19. **[144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH**
486.29 **RESPECT TO CLIENTS.**

486.30 Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care
486.31 provider shall provide the client or the client's representative a written notice of the rights
486.32 under section 144A.44 before the initiation of services to that client. The provider shall
486.33 make all reasonable efforts to provide notice of the rights to the client or the client's
486.34 representative in a language the client or client's representative can understand.

487.1 (b) In addition to the text of the home care bill of rights in section 144A.44,
487.2 subdivision 1, the notice shall also contain the following statement describing how to file
487.3 a complaint with these offices.

487.4 "If you have a complaint about the provider or the person providing your
487.5 home care services, you may call, write, or visit the Office of Health Facility
487.6 Complaints, Minnesota Department of Health. You may also contact the Office of
487.7 Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health
487.8 and Developmental Disabilities."

487.9 The statement should include the telephone number, Web site address, e-mail
487.10 address, mailing address, and street address of the Office of Health Facility Complaints at
487.11 the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care,
487.12 and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The
487.13 statement should also include the home care provider's name, address, e-mail, telephone
487.14 number, and name or title of the person at the provider to whom problems or complaints
487.15 may be directed. It must also include a statement that the home care provider will not
487.16 retaliate because of a complaint.

487.17 (c) The home care provider shall obtain written acknowledgment of the client's
487.18 receipt of the home care bill of rights or shall document why an acknowledgment cannot
487.19 be obtained. The acknowledgment may be obtained from the client or the client's
487.20 representative. Acknowledgment of receipt shall be retained in the client's record.

487.21 Subd. 2. **Notice of services for dementia, Alzheimer's disease, or related**
487.22 **disorders.** The home care provider that provides services to clients with dementia shall
487.23 provide in written or electronic form, to clients and families or other persons who request
487.24 it, a description of the training program and related training it provides, including the
487.25 categories of employees trained, the frequency of training, and the basic topics covered.
487.26 This information satisfies the disclosure requirements in section 325F.72, subdivision
487.27 2, clause (4).

487.28 Subd. 3. **Statement of home care services.** Prior to the initiation of services,
487.29 a home care provider must provide to the client or the client's representative a written
487.30 statement which identifies if the provider has a basic or comprehensive home care license,
487.31 the services the provider is authorized to provide, and which services the provider cannot
487.32 provide under the scope of the provider's license. The home care provider shall obtain
487.33 written acknowledgment from the clients that the provider has provided the statement or
487.34 must document why the provider could not obtain the acknowledgment.

487.35 Subd. 4. **Acceptance of clients.** No home care provider may accept a person as a
487.36 client unless the home care provider has staff, sufficient in qualifications, competency,

488.1 and numbers, to adequately provide the services agreed to in the service plan and that
488.2 are within the provider's scope of practice.

488.3 Subd. 5. **Referrals.** If a home care provider reasonably believes that a client is in
488.4 need of another medical or health service, including a licensed health professional, or
488.5 social service provider, the home care provider shall:

488.6 (1) determine the client's preferences with respect to obtaining the service; and

488.7 (2) inform the client of resources available, if known, to assist the client in obtaining
488.8 services.

488.9 Subd. 6. **Initiation of services.** When a provider initiates services and the
488.10 individualized review or assessment required in subdivisions 7 and 8 has not been
488.11 completed, the provider must complete a temporary plan and agreement with the client for
488.12 services.

488.13 Subd. 7. **Basic individualized client review and monitoring.** (a) When services
488.14 being provided are basic home care services, an individualized initial review of the client's
488.15 needs and preferences must be conducted at the client's residence with the client or client's
488.16 representative. This initial review must be completed within 30 days after the initiation of
488.17 the home care services.

488.18 (b) Client monitoring and review must be conducted as needed based on changes
488.19 in the needs of the client and cannot exceed 90 days from the date of the last review.
488.20 The monitoring and review may be conducted at the client's residence or through the
488.21 utilization of telecommunication methods based on practice standards that meet the
488.22 individual client's needs.

488.23 Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When
488.24 the services being provided are comprehensive home care services, an individualized
488.25 initial assessment must be conducted in-person by a registered nurse. When the services
488.26 are provided by other licensed health professionals, the assessment must be conducted by
488.27 the appropriate health professional. This initial assessment must be completed within five
488.28 days after initiation of home care services.

488.29 (b) Client monitoring and reassessment must be conducted in the client's home no
488.30 more than 14 days after initiation of services.

488.31 (c) Ongoing client monitoring and reassessment must be conducted as needed based
488.32 on changes in the needs of the client and cannot exceed 90 days from the last date of the
488.33 assessment. The monitoring and reassessment may be conducted at the client's residence
488.34 or through the utilization of telecommunication methods based on practice standards that
488.35 meet the individual client's needs.

489.1 Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later
489.2 than 14 days after the initiation of services, a home care provider shall finalize a current
489.3 written service plan.

489.4 (b) The service plan and any revisions must include a signature or other
489.5 authentication by the home care provider and by the client or the client's representative
489.6 documenting agreement on the services to be provided. The service plan must be revised,
489.7 if needed, based on client review or reassessment under subdivisions 7 and 8. The provider
489.8 must provide information to the client about changes to the provider's fee for services and
489.9 how to contact the Office of the Ombudsman for Long-Term Care.

489.10 (c) The home care provider must implement and provide all services required by
489.11 the current service plan.

489.12 (d) The service plan and revised service plan must be entered into the client's record,
489.13 including notice of a change in a client's fees when applicable.

489.14 (e) Staff providing home care services must be informed of the current written
489.15 service plan.

489.16 (f) The service plan must include:

489.17 (1) a description of the home care services to be provided, the fees for services, and
489.18 the frequency of each service, according to the client's current review or assessment and
489.19 client preferences;

489.20 (2) the identification of the staff or categories of staff who will provide the services;

489.21 (3) the schedule and methods of monitoring reviews or assessments of the client;

489.22 (4) the frequency of sessions of supervision of staff and type of personnel who
489.23 will supervise staff; and

489.24 (5) a contingency plan that includes:

489.25 (i) the action to be taken by the home care provider and by the client or client's
489.26 representative if the scheduled service cannot be provided;

489.27 (ii) information and method for a client or client's representative to contact the
489.28 home care provider;

489.29 (iii) names and contact information of persons the client wishes to have notified
489.30 in an emergency or if there is a significant adverse change in the client's condition,
489.31 including identification of and information as to who has authority to sign for the client in
489.32 an emergency; and

489.33 (iv) the circumstances in which emergency medical services are not to be summoned
489.34 consistent with chapters 145B and 145C, and declarations made by the client under those
489.35 chapters.

490.1 Subd. 10. Termination of service plan. (a) If a home care provider terminates a
490.2 service plan with a client, and the client continues to need home care services, the home
490.3 care provider shall provide the client and the client's representative, if any, with a written
490.4 notice of termination which includes the following information:

490.5 (1) the effective date of termination;

490.6 (2) the reason for termination;

490.7 (3) a list of known licensed home care providers in the client's immediate geographic
490.8 area;

490.9 (4) a statement that the home care provider will participate in a coordinated transfer
490.10 of care of the client to another home care provider, health care provider, or caregiver, as
490.11 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

490.12 (5) the name and contact information of a person employed by the home care
490.13 provider with whom the client may discuss the notice of termination; and

490.14 (6) if applicable, a statement that the notice of termination of home care services
490.15 does not constitute notice of termination of the housing with services contract with a
490.16 housing with services establishment.

490.17 (b) When the home care provider voluntarily discontinues services to all clients, the
490.18 home care provider must notify the commissioner, lead agencies, and the ombudsman for
490.19 long-term care about its clients and comply with the requirements in this subdivision.

490.20 Subd. 11. Client complaint and investigative process. (a) The home care
490.21 provider must have a written policy and system for receiving, investigating, reporting,
490.22 and attempting to resolve complaints from its clients or clients' representatives. The
490.23 policy should clearly identify the process by which clients may file a complaint or concern
490.24 about home care services and an explicit statement that the home care provider will not
490.25 discriminate or retaliate against a client for expressing concerns or complaints. A home
490.26 care provider must have a process in place to conduct investigations of complaints made
490.27 by the client or the client's representative about the services in the client's plan that are or
490.28 are not being provided or other items covered in the client's home care bill of rights. This
490.29 complaint system must provide reasonable accommodations for any special needs of the
490.30 client or client's representative if requested.

490.31 (b) The home care provider must document the complaint, name of the client,
490.32 investigation, and resolution of each complaint filed. The home care provider must
490.33 maintain a record of all activities regarding complaints received, including the date the
490.34 complaint was received, and the home care provider's investigation and resolution of the
490.35 complaint. This complaint record must be kept for each event for at least two years after
490.36 the date of entry and must be available to the commissioner for review.

491.1 (c) The required complaint system must provide for written notice to each client or
491.2 client's representative that includes:

491.3 (1) the client's right to complain to the home care provider about the services received;

491.4 (2) the name or title of the person or persons with the home care provider to contact
491.5 with complaints;

491.6 (3) the method of submitting a complaint to the home care provider; and

491.7 (4) a statement that the provider is prohibited against retaliation according to
491.8 paragraph (d).

491.9 (d) A home care provider must not take any action that negatively affects a client
491.10 in retaliation for a complaint made or a concern expressed by the client or the client's
491.11 representative.

491.12 Subd. 12. **Disaster planning and emergency preparedness plan.** The home care
491.13 provider must have a written plan of action to facilitate the management of the client's care
491.14 and services in response to a natural disaster, such as flood and storms, or other emergencies
491.15 that may disrupt the home care provider's ability to provide care or services. The licensee
491.16 must provide adequate orientation and training of staff on emergency preparedness.

491.17 Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a
491.18 client, family member, or other caregiver of the client requests that an employee or other
491.19 agent of the home care provider discontinue a life-sustaining treatment, the employee or
491.20 agent receiving the request:

491.21 (1) shall take no action to discontinue the treatment; and

491.22 (2) shall promptly inform the supervisor or other agent of the home care provider of
491.23 the client's request.

491.24 (b) Upon being informed of a request for termination of treatment, the home care
491.25 provider shall promptly:

491.26 (1) inform the client that the request will be made known to the physician who
491.27 ordered the client's treatment;

491.28 (2) inform the physician of the client's request; and

491.29 (3) work with the client and the client's physician to comply with the provisions of
491.30 the Health Care Directive Act in chapter 145C.

491.31 (c) This section does not require the home care provider to discontinue treatment,
491.32 except as may be required by law or court order.

491.33 (d) This section does not diminish the rights of clients to control their treatments,
491.34 refuse services, or terminate their relationships with the home care provider.

491.35 (e) This section shall be construed in a manner consistent with chapter 145B or
491.36 145C, whichever applies, and declarations made by clients under those chapters.

492.1 Sec. 20. **[144A.4792] MEDICATION MANAGEMENT.**

492.2 **Subdivision 1. Medication management services; comprehensive home care**
492.3 **license.** (a) This subdivision applies only to home care providers with a comprehensive
492.4 home care license that provide medication management services to clients. Medication
492.5 management services may not be provided by a home care provider who has a basic
492.6 home care license.

492.7 (b) A comprehensive home care provider who provides medication management
492.8 services must develop, implement, and maintain current written medication management
492.9 policies and procedures. The policies and procedures must be developed under the
492.10 supervision and direction of a registered nurse, licensed health professional, or pharmacist
492.11 consistent with current practice standards and guidelines.

492.12 (c) The written policies and procedures must address requesting and receiving
492.13 prescriptions for medications; preparing and giving medications; verifying that
492.14 prescription drugs are administered as prescribed; documenting medication management
492.15 activities; controlling and storing medications; monitoring and evaluating medication use;
492.16 resolving medication errors; communicating with the prescriber, pharmacist, and client
492.17 and client representative, if any; disposing of unused medications; and educating clients
492.18 and client representatives about medications. When controlled substances are being
492.19 managed, the policies and procedures must also identify how the provider will ensure
492.20 security and accountability for the overall management, control, and disposition of those
492.21 substances in compliance with state and federal regulations and with subdivision 22.

492.22 **Subd. 2. Provision of medication management services.** (a) For each client who
492.23 requests medication management services, the comprehensive home care provider shall,
492.24 prior to providing medication management services, have a registered nurse, licensed
492.25 health professional, or authorized prescriber under section 151.37 conduct an assessment
492.26 to determine what medication management services will be provided and how the services
492.27 will be provided. This assessment must be conducted face-to-face with the client. The
492.28 assessment must include an identification and review of all medications the client is known
492.29 to be taking. The review and identification must include indications for medications, side
492.30 effects, contraindications, allergic or adverse reactions, and actions to address these issues.

492.31 (b) The assessment must identify interventions needed in management of
492.32 medications to prevent diversion of medication by the client or others who may have
492.33 access to the medications. "Diversion of medications" means the misuse, theft, or illegal
492.34 or improper disposition of medications.

492.35 **Subd. 3. Individualized medication monitoring and reassessment.** The
492.36 comprehensive home care provider must monitor and reassess the client's medication

493.1 management services as needed under subdivision 14 when the client presents with
493.2 symptoms or other issues that may be medication-related and, at a minimum, annually.

493.3 Subd. 4. **Client refusal.** The home care provider must document in the client's
493.4 record any refusal for an assessment for medication management by the client. The
493.5 provider must discuss with the client the possible consequences of the client's refusal and
493.6 document the discussion in the client's record.

493.7 Subd. 5. **Individualized medication management plan.** (a) For each client
493.8 receiving medication management services, the comprehensive home care provider must
493.9 prepare and include in the service plan a written statement of the medication management
493.10 services that will be provided to the client. The provider must develop and maintain a
493.11 current individualized medication management record for each client based on the client's
493.12 assessment that must contain the following:

493.13 (1) a statement describing the medication management services that will be provided;

493.14 (2) a description of storage of medications based on the client's needs and
493.15 preferences, risk of diversion, and consistent with the manufacturer's directions;

493.16 (3) documentation of specific client instructions relating to the administration
493.17 of medications;

493.18 (4) identification of persons responsible for monitoring medication supplies and
493.19 ensuring that medication refills are ordered on a timely basis;

493.20 (5) identification of medication management tasks that may be delegated to
493.21 unlicensed personnel;

493.22 (6) procedures for staff notifying a registered nurse or appropriate licensed health
493.23 professional when a problem arises with medication management services; and

493.24 (7) any client-specific requirements relating to documenting medication
493.25 administration, verifications that all medications are administered as prescribed, and
493.26 monitoring of medication use to prevent possible complications or adverse reactions.

493.27 (b) The medication management record must be current and updated when there are
493.28 any changes.

493.29 Subd. 6. **Administration of medication.** Medications may be administered by a
493.30 nurse, physician, or other licensed health practitioner authorized to administer medications
493.31 or by unlicensed personnel who have been delegated medication administration tasks by
493.32 a registered nurse.

493.33 Subd. 7. **Delegation of medication administration.** When administration of
493.34 medications is delegated to unlicensed personnel, the comprehensive home care provider
493.35 must ensure that the registered nurse has:

494.1 (1) instructed the unlicensed personnel in the proper methods to administer the
494.2 medications, and the unlicensed personnel has demonstrated ability to competently follow
494.3 the procedures;

494.4 (2) specified, in writing, specific instructions for each client and documented those
494.5 instructions in the client's records; and

494.6 (3) communicated with the unlicensed personnel about the individual needs of
494.7 the client.

494.8 **Subd. 8. Documentation of administration of medications.** Each medication
494.9 administered by comprehensive home care provider staff must be documented in the
494.10 client's record. The documentation must include the signature and title of the person
494.11 who administered the medication. The documentation must include the medication
494.12 name, dosage, date and time administered, and method and route of administration. The
494.13 staff must document the reason why medication administration was not completed as
494.14 prescribed and document any follow-up procedures that were provided to meet the client's
494.15 needs when medication was not administered as prescribed and in compliance with the
494.16 client's medication management plan.

494.17 **Subd. 9. Documentation of medication setup.** Documentation of dates of
494.18 medication setup, name of medication, quantity of dose, times to be administered, route
494.19 of administration, and name of person completing medication setup must be done at
494.20 time of setup.

494.21 **Subd. 10. Medication management for clients who will be away from home.** (a)
494.22 A home care provider who is providing medication management services to the client and
494.23 controls the client's access to the medications must develop and implement policies and
494.24 procedures for giving accurate and current medications to clients for planned or unplanned
494.25 times away from home according to the client's individualized medication management
494.26 plan. The policy and procedures must state that:

494.27 (1) for planned time away, the medications must be obtained from the pharmacy or
494.28 set up by the registered nurse according to appropriate state and federal laws and nursing
494.29 standards of practice;

494.30 (2) for unplanned time away, when the pharmacy is not able to provide the
494.31 medications, a licensed nurse or unlicensed personnel shall give the client or client's
494.32 representative medications in amounts and dosages needed for the length of the anticipated
494.33 absence, not to exceed 120 hours;

494.34 (3) the client, or the client's representative, must be provided written information
494.35 on medications, including any special instructions for administering or handling the
494.36 medications, including controlled substances;

495.1 (4) the medications must be placed in a medication container or containers
495.2 appropriate to the provider's medication system and must be labeled with the client's name
495.3 and the dates and times that the medications are scheduled; and

495.4 (5) the client or client's representative must be provided in writing the home care
495.5 provider's name and information on how to contact the home care provider.

495.6 (b) For unplanned time away when the licensed nurse is not available, the registered
495.7 nurse may delegate this task to unlicensed personnel if:

495.8 (1) the registered nurse has trained the unlicensed staff and determined the
495.9 unlicensed staff is competent to follow the procedures for giving medications to clients;

495.10 (2) the registered nurse has developed written procedures for the unlicensed
495.11 personnel, including any special instructions or procedures regarding controlled substances
495.12 that are prescribed for the client. The procedures must address:

495.13 (i) the type of container or containers to be used for the medications appropriate to
495.14 the provider's medication system;

495.15 (ii) how the container or containers must be labeled;

495.16 (iii) the written information about the medications to be given to the client or client's
495.17 representative;

495.18 (iv) how the unlicensed staff must document in the client's record that medications
495.19 have been given to the client or the client's representative, including documenting the date
495.20 the medications were given to the client or the client's representative and who received the
495.21 medications, the person who gave the medications to the client, the number of medications
495.22 that were given to the client, and other required information;

495.23 (v) how the registered nurse shall be notified that medications have been given to
495.24 the client or client's representative and whether the registered nurse needs to be contacted
495.25 before the medications are given to the client or the client's representative; and

495.26 (vi) a review by the registered nurse of the completion of this task to verify that this
495.27 task was completed accurately by the unlicensed personnel.

495.28 Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home
495.29 care provider must determine whether the comprehensive home care provider shall require
495.30 a prescription for all medications the provider manages. The comprehensive home care
495.31 provider must inform the client or the client's representative whether the comprehensive
495.32 home care provider requires a prescription for all over-the-counter and dietary supplements
495.33 before the comprehensive home care provider agrees to manage those medications.

495.34 Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.**
495.35 A comprehensive home care provider providing medication management services for
495.36 over-the-counter drugs or dietary supplements must retain those items in the original labeled

496.1 container with directions for use prior to setting up for immediate or later administration.

496.2 The provider must verify that the medications are up-to-date and stored as appropriate.

496.3 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
496.4 prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed
496.5 medications that the comprehensive home care provider is managing for the client.

496.6 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least
496.7 every 12 months or more frequently as indicated by the assessment in subdivision 2.
496.8 Prescriptions for controlled substances must comply with chapter 152.

496.9 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an
496.10 authorized prescriber must be received by a nurse or pharmacist. The order must be
496.11 handled according to Minnesota Rules, part 6800.6200.

496.12 Subd. 16. **Written or electronic prescription.** When a written or electronic
496.13 prescription is received, it must be communicated to the registered nurse in charge and
496.14 recorded or placed in the client's record.

496.15 Subd. 17. **Records confidential.** A prescription or order received verbally, in
496.16 writing, or electronically must be kept confidential according to sections 144.291 to
496.17 144.298 and 144A.44.

496.18 Subd. 18. **Medications provided by client or family members.** When the
496.19 comprehensive home care provider is aware of any medications or dietary supplements
496.20 that are being used by the client and are not included in the assessment for medication
496.21 management services, the staff must advise the registered nurse and document that in
496.22 the client's record.

496.23 Subd. 19. **Storage of medications.** A comprehensive home care provider providing
496.24 storage of medications outside of the client's private living space must store all prescription
496.25 medications in securely locked and substantially constructed compartments according to
496.26 the manufacturer's directions and permit only authorized personnel to have access.

496.27 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for
496.28 immediate or later administration, must be kept in the original container in which it was
496.29 dispensed by the pharmacy bearing the original prescription label with legible information
496.30 including the expiration or beyond-use date of a time-dated drug.

496.31 Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or
496.32 saved for use by anyone other than the client.

496.33 Subd. 22. **Disposition of medications.** (a) Any current medications being managed
496.34 by the comprehensive home care provider must be given to the client or the client's
496.35 representative when the client's service plan ends or medication management services are
496.36 no longer part of the service plan. Medications that have been stored in the client's private

497.1 living space for a client who is deceased or that have been discontinued or that have
497.2 expired may be given to the client or the client's representative for disposal.

497.3 (b) The comprehensive home care provider will dispose of any medications
497.4 remaining with the comprehensive home care provider that are discontinued or expired or
497.5 upon the termination of the service contract or the client's death according to state and
497.6 federal regulations for disposition of medications and controlled substances.

497.7 (c) Upon disposition, the comprehensive home care provider must document in the
497.8 client's record the disposition of the medication including the medication's name, strength,
497.9 prescription number as applicable, quantity, to whom the medications were given, date of
497.10 disposition, and names of staff and other individuals involved in the disposition.

497.11 Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing
497.12 medication management must develop and implement procedures for loss or spillage of all
497.13 controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must
497.14 require that when a spillage of a controlled substance occurs, a notation must be made
497.15 in the client's record explaining the spillage and the actions taken. The notation must
497.16 be signed by the person responsible for the spillage and include verification that any
497.17 contaminated substance was disposed of according to state or federal regulations.

497.18 (b) The procedures must require the comprehensive home care provider of
497.19 medication management to investigate any known loss or unaccounted for prescription
497.20 drugs and take appropriate action required under state or federal regulations and document
497.21 the investigation in required records.

497.22 Sec. 21. **[144A.4793] TREATMENT AND THERAPY MANAGEMENT**
497.23 **SERVICES.**

497.24 Subdivision 1. **Providers with a comprehensive home care license.** This section
497.25 applies only to home care providers with a comprehensive home care license that provide
497.26 treatment or therapy management services to clients. Treatment or therapy management
497.27 services cannot be provided by a home care provider that has a basic home care license.

497.28 Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who
497.29 provides treatment and therapy management services must develop, implement, and
497.30 maintain up-to-date written treatment or therapy management policies and procedures.
497.31 The policies and procedures must be developed under the supervision and direction of
497.32 a registered nurse or appropriate licensed health professional consistent with current
497.33 practice standards and guidelines.

497.34 (b) The written policies and procedures must address requesting and receiving
497.35 orders or prescriptions for treatments or therapies, providing the treatment or therapy,

498.1 documenting of treatment or therapy activities, educating and communicating with clients
498.2 about treatments or therapy they are receiving, monitoring and evaluating the treatment
498.3 and therapy, and communicating with the prescriber.

498.4 Subd. 3. **Individualized treatment or therapy management plan.** For each
498.5 client receiving management of ordered or prescribed treatments or therapy services, the
498.6 comprehensive home care provider must prepare and include in the service plan a written
498.7 statement of the treatment or therapy services that will be provided to the client. The
498.8 provider must also develop and maintain a current individualized treatment and therapy
498.9 management record for each client which must contain at least the following:

498.10 (1) a statement of the type of services that will be provided;

498.11 (2) documentation of specific client instructions relating to the treatments or therapy
498.12 administration;

498.13 (3) identification of treatment or therapy tasks that will be delegated to unlicensed
498.14 personnel;

498.15 (4) procedures for notifying a registered nurse or appropriate licensed health
498.16 professional when a problem arises with treatments or therapy services; and

498.17 (5) any client-specific requirements relating to documentation of treatment
498.18 and therapy received, verification that all treatment and therapy was administered as
498.19 prescribed, and monitoring of treatment or therapy to prevent possible complications or
498.20 adverse reactions. The treatment or therapy management record must be current and
498.21 updated when there are any changes.

498.22 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed
498.23 treatments or therapies must be administered by a nurse, physician, or other licensed health
498.24 professional authorized to perform the treatment or therapy, or may be delegated or assigned
498.25 to unlicensed personnel by the licensed health professional according to the appropriate
498.26 practice standards for delegation or assignment. When administration of a treatment or
498.27 therapy is delegated or assigned to unlicensed personnel, the home care provider must
498.28 ensure that the registered nurse or authorized licensed health professional has:

498.29 (1) instructed the unlicensed personnel in the proper methods with respect to each
498.30 client and the unlicensed personnel has demonstrated the ability to competently follow
498.31 the procedures;

498.32 (2) specified, in writing, specific instructions for each client and documented those
498.33 instructions in the client's record; and

498.34 (3) communicated with the unlicensed personnel about the individual needs of
498.35 the client.

499.1 Subd. 5. **Documentation of administration of treatments and therapies.** Each
499.2 treatment or therapy administered by a comprehensive home care provider must be
499.3 documented in the client's record. The documentation must include the signature and title
499.4 of the person who administered the treatment or therapy and must include the date and
499.5 time of administration. When treatment or therapies are not administered as ordered or
499.6 prescribed, the provider must document the reason why it was not administered and any
499.7 follow-up procedures that were provided to meet the client's needs.

499.8 Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or
499.9 electronically recorded order or prescription for all treatments and therapies. The order
499.10 must contain the name of the client, description of the treatment or therapy to be provided,
499.11 and the frequency and other information needed to administer the treatment or therapy.

499.12 Sec. 22. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

499.13 Subdivision 1. **Client record.** (a) The home care provider must maintain records
499.14 for each client for whom it is providing services. Entries in the client records must be
499.15 current, legible, permanently recorded, dated, and authenticated with the name and title
499.16 of the person making the entry.

499.17 (b) Client records, whether written or electronic, must be protected against loss,
499.18 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable
499.19 relevant federal and state laws. The home care provider shall establish and implement
499.20 written procedures to control use, storage, and security of client's records and establish
499.21 criteria for release of client information.

499.22 (c) The home care provider may not disclose to any other person any personal,
499.23 financial, medical, or other information about the client, except:

499.24 (1) as may be required by law;

499.25 (2) to employees or contractors of the home care provider, another home care
499.26 provider, other health care practitioner or provider, or inpatient facility needing
499.27 information in order to provide services to the client, but only such information that
499.28 is necessary for the provision of services;

499.29 (3) to persons authorized in writing by the client or the client's representative to
499.30 receive the information, including third-party payers; and

499.31 (4) to representatives of the commissioner authorized to survey or investigate home
499.32 care providers under this chapter or federal laws.

499.33 Subd. 2. **Access to records.** The home care provider must ensure that the
499.34 appropriate records are readily available to employees or contractors authorized to access

500.1 the records. Client records must be maintained in a manner that allows for timely access,
500.2 printing, or transmission of the records.

500.3 Subd. 3. **Contents of client record.** Contents of a client record include the
500.4 following for each client:

500.5 (1) identifying information, including the client's name, date of birth, address, and
500.6 telephone number;

500.7 (2) the name, address, and telephone number of an emergency contact, family
500.8 members, client's representative, if any, or others as identified;

500.9 (3) names, addresses, and telephone numbers of the client's health and medical
500.10 service providers and other home care providers, if known;

500.11 (4) health information, including medical history, allergies, and when the provider
500.12 is managing medications, treatments or therapies that require documentation, and other
500.13 relevant health records;

500.14 (5) client's advance directives, if any;

500.15 (6) the home care provider's current and previous assessments and service plans;

500.16 (7) all records of communications pertinent to the client's home care services;

500.17 (8) documentation of significant changes in the client's status and actions taken in
500.18 response to the needs of the client including reporting to the appropriate supervisor or
500.19 health care professional;

500.20 (9) documentation of incidents involving the client and actions taken in response
500.21 to the needs of the client including reporting to the appropriate supervisor or health
500.22 care professional;

500.23 (10) documentation that services have been provided as identified in the service plan;

500.24 (11) documentation that the client has received and reviewed the home care bill
500.25 of rights;

500.26 (12) documentation that the client has been provided the statement of disclosure on
500.27 limitations of services under section 144A.4791, subdivision 3;

500.28 (13) documentation of complaints received and resolution;

500.29 (14) discharge summary, including service termination notice and related
500.30 documentation, when applicable; and

500.31 (15) other documentation required under this chapter and relevant to the client's
500.32 services or status.

500.33 Subd. 4. **Transfer of client records.** If a client transfers to another home care
500.34 provider or other health care practitioner or provider, or is admitted to an inpatient facility,
500.35 the home care provider, upon request of the client or the client's representative, shall take

501.1 steps to ensure a coordinated transfer including sending a copy or summary of the client's
501.2 record to the new home care provider, facility, or the client, as appropriate.

501.3 Subd. 5. **Record retention.** Following the client's discharge or termination of
501.4 services, a home care provider must retain a client's record for at least five years, or as
501.5 otherwise required by state or federal regulations. Arrangements must be made for secure
501.6 storage and retrieval of client records if the home care provider ceases business.

501.7 Sec. 23. **[144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.**

501.8 Subdivision 1. **Qualifications, training, and competency.** All staff providing home
501.9 care services must: (1) be trained and competent in the provision of home care services
501.10 consistent with current practice standards appropriate to the client's needs; and (2) be
501.11 informed of the home care bill of rights under section 144A.44.

501.12 Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health
501.13 professionals and nurses providing home care services as an employee of a licensed home
501.14 care provider must possess current Minnesota license or registration to practice.

501.15 (b) Licensed health professionals and registered nurses must be competent in
501.16 assessing client needs, planning appropriate home care services to meet client needs,
501.17 implementing services, and supervising staff if assigned.

501.18 (c) Nothing in this section limits or expands the rights of nurses or licensed health
501.19 professionals to provide services within the scope of their licenses or registrations, as
501.20 provided by law.

501.21 Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home
501.22 care services must have:

501.23 (1) successfully completed a training and competency evaluation appropriate to
501.24 the services provided by the home care provider and the topics listed in subdivision 7,
501.25 paragraph (b); or

501.26 (2) demonstrated competency by satisfactorily completing a written or oral test on
501.27 the tasks the unlicensed personnel will perform and in the topics listed in subdivision
501.28 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7,
501.29 paragraph (b), clauses (5), (7), and (8), by a practical skills test.

501.30 Unlicensed personnel providing home care services for a basic home care provider may
501.31 not perform delegated nursing or therapy tasks.

501.32 (b) Unlicensed personnel performing delegated nursing tasks for a comprehensive
501.33 home care provider must:

501.34 (1) have successfully completed training and demonstrated competency by
501.35 successfully completing a written or oral test of the topics in subdivision 7, paragraphs (b)

502.1 and (c), and a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5)
502.2 and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;

502.3 (2) satisfy the current requirements of Medicare for training or competency of home
502.4 health aides or nursing assistants, as provided by Code of Federal Regulations, title 42,
502.5 section 483 or section 484.36; or

502.6 (3) have, before April 19, 1993, completed a training course for nursing assistants
502.7 that was approved by the commissioner.

502.8 (c) Unlicensed personnel performing therapy or treatment tasks delegated or
502.9 assigned by a licensed health professional must meet the requirements for delegated
502.10 tasks in subdivision 4 and any other training or competency requirements within the
502.11 licensed health professional scope of practice relating to delegation or assignment of tasks
502.12 to unlicensed personnel.

502.13 Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health
502.14 professional may delegate tasks only to staff that are competent and possess the knowledge
502.15 and skills consistent with the complexity of the tasks and according to the appropriate
502.16 Minnesota Practice Act. The comprehensive home care provider must establish and
502.17 implement a system to communicate up-to-date information to the registered nurse or
502.18 licensed health professional regarding the current available staff and their competency so
502.19 the registered nurse or licensed health professional has sufficient information to determine
502.20 the appropriateness of delegating tasks to meet individual client needs and preferences.

502.21 Subd. 5. **Individual contractors.** When a home care provider contracts with an
502.22 individual contractor excluded from licensure under section 144A.471 to provide home
502.23 care services, the contractor must meet the same requirements required by this section for
502.24 personnel employed by the home care provider.

502.25 Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary
502.26 staffing agency excluded from licensure under section 144A.471, those individuals must
502.27 meet the same requirements required by this section for personnel employed by the home
502.28 care provider and shall be treated as if they are staff of the home care provider.

502.29 Subd. 7. **Requirements for instructors, training content, and competency**
502.30 **evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must
502.31 meet the following requirements:

502.32 (1) training and competency evaluations of unlicensed personnel providing basic
502.33 home care services must be conducted by individuals with work experience and training in
502.34 providing home care services listed in section 144A.471, subdivisions 6 and 7; and

502.35 (2) training and competency evaluations of unlicensed personnel providing
502.36 comprehensive home care services must be conducted by a registered nurse, or another

503.1 instructor may provide training in conjunction with the registered nurse. If the home care
503.2 provider is providing services by licensed health professionals only, then that specific
503.3 training and competency evaluation may be conducted by the licensed health professionals
503.4 as appropriate.

503.5 (b) Training and competency evaluations for all unlicensed personnel must include
503.6 the following:

503.7 (1) documentation requirements for all services provided;

503.8 (2) reports of changes in the client's condition to the supervisor designated by the
503.9 home care provider;

503.10 (3) basic infection control, including blood-borne pathogens;

503.11 (4) maintenance of a clean and safe environment;

503.12 (5) appropriate and safe techniques in personal hygiene and grooming, including:

503.13 (i) hair care and bathing;

503.14 (ii) care of teeth, gums, and oral prosthetic devices;

503.15 (iii) care and use of hearing aids; and

503.16 (iv) dressing and assisting with toileting;

503.17 (6) training on the prevention of falls for providers working with the elderly or
503.18 individuals at risk of falls;

503.19 (7) standby assistance techniques and how to perform them;

503.20 (8) medication, exercise, and treatment reminders;

503.21 (9) basic nutrition, meal preparation, food safety, and assistance with eating;

503.22 (10) preparation of modified diets as ordered by a licensed health professional;

503.23 (11) communication skills that include preserving the dignity of the client and

503.24 showing respect for the client and the client's preferences, cultural background, and family;

503.25 (12) awareness of confidentiality and privacy;

503.26 (13) understanding appropriate boundaries between staff and clients and the client's
503.27 family;

503.28 (14) procedures to utilize in handling various emergency situations; and

503.29 (15) awareness of commonly used health technology equipment and assistive devices.

503.30 (c) In addition to paragraph (b), training and competency evaluation for unlicensed
503.31 personnel providing comprehensive home care services must include:

503.32 (1) observation, reporting, and documenting of client status;

503.33 (2) basic knowledge of body functioning and changes in body functioning, injuries,
503.34 or other observed changes that must be reported to appropriate personnel;

503.35 (3) reading and recording temperature, pulse, and respirations of the client;

503.36 (4) recognizing physical, emotional, cognitive, and developmental needs of the client;

- 504.1 (5) safe transfer techniques and ambulation;
- 504.2 (6) range of motioning and positioning; and
- 504.3 (7) administering medications or treatments as required.

504.4 (d) When the registered nurse or licensed health professional delegates tasks, they
504.5 must ensure that prior to the delegation the unlicensed personnel is trained in the proper
504.6 methods to perform the tasks or procedures for each client and are able to demonstrate
504.7 the ability to competently follow the procedures and perform the tasks. If an unlicensed
504.8 personnel has not regularly performed the delegated home care task for a period of 24
504.9 consecutive months, the unlicensed personnel must demonstrate competency in the task
504.10 to the registered nurse or appropriate licensed health professional. The registered nurse
504.11 or licensed health professional must document instructions for the delegated tasks in
504.12 the client's record.

504.13 Sec. 24. **[144A.4796] ORIENTATION AND ANNUAL TRAINING**
504.14 **REQUIREMENTS.**

504.15 Subdivision 1. **Orientation of staff and supervisors to home care.** All staff
504.16 providing and supervising direct home care services must complete an orientation to home
504.17 care licensing requirements and regulations before providing home care services to clients.
504.18 The orientation may be incorporated into the training required under subdivision 6. The
504.19 orientation need only be completed once for each staff person and is not transferable
504.20 to another home care provider.

504.21 Subd. 2. **Content.** The orientation must contain the following topics:

- 504.22 (1) an overview of sections 144A.43 to 144A.4798;
- 504.23 (2) introduction and review of all the provider's policies and procedures related to
504.24 the provision of home care services;
- 504.25 (3) handling of emergencies and use of emergency services;
- 504.26 (4) compliance with and reporting of the maltreatment of minors or vulnerable
504.27 adults under sections 626.556 and 626.557;
- 504.28 (5) home care bill of rights, under section 144A.44;
- 504.29 (6) handling of clients' complaints; reporting of complaints and where to report
504.30 complaints including information on the Office of Health Facility Complaints and the
504.31 Common Entry Point;
- 504.32 (7) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
504.33 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
504.34 Ombudsman at the Department of Human Services, county managed care advocates,
504.35 or other relevant advocacy services; and

505.1 (8) review of the types of home care services the employee will be providing and
505.2 the provider's scope of licensure.

505.3 Subd. 3. **Verification and documentation of orientation.** Each home care provider
505.4 shall retain evidence in the employee record of each staff person having completed the
505.5 orientation required by this section.

505.6 Subd. 4. **Orientation to client.** Staff providing home care services must be oriented
505.7 specifically to each individual client and the services to be provided. This orientation may
505.8 be provided in person, orally, in writing, or electronically.

505.9 Subd. 5. **Training required relating to Alzheimer's disease and related disorders.**
505.10 For home care providers that provide services for persons with Alzheimer's or related
505.11 disorders, all direct care staff and supervisors working with those clients must receive
505.12 training that includes a current explanation of Alzheimer's disease and related disorders,
505.13 effective approaches to use to problem solve when working with a client's challenging
505.14 behaviors, and how to communicate with clients who have Alzheimer's or related disorders.

505.15 Subd. 6. **Required annual training.** All staff that perform direct home care
505.16 services must complete at least eight hours of annual training for each 12 months of
505.17 employment. The training may be obtained from the home care provider or another source
505.18 and must include topics relevant to the provision of home care services. The annual
505.19 training must include:

505.20 (1) training on reporting of maltreatment of minors under section 626.556 and
505.21 maltreatment of vulnerable adults under section 626.557, whichever is applicable to the
505.22 services provided;

505.23 (2) review of the home care bill of rights in section 144A.44;

505.24 (3) review of infection control techniques used in the home and implementation of
505.25 infection control standards including a review of hand washing techniques; the need for
505.26 and use of protective gloves, gowns, and masks; appropriate disposal of contaminated
505.27 materials and equipment, such as dressings, needles, syringes, and razor blades;
505.28 disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of
505.29 communicable diseases; and

505.30 (4) review of the provider's policies and procedures relating to the provision of home
505.31 care services and how to implement those policies and procedures.

505.32 Subd. 7. **Documentation.** A home care provider must retain documentation in the
505.33 employee records of the staff that have satisfied the orientation and training requirements
505.34 of this section.

505.35 Sec. 25. **[144A.4797] PROVISION OF SERVICES.**

506.1 Subdivision 1. **Availability of contact person to staff.** (a) A home care provider
506.2 with a basic home care license must have a person available to staff for consultation on
506.3 items relating to the provision of services or about the client.

506.4 (b) A home care provider with a comprehensive home care license must have a
506.5 registered nurse available for consultation to staff performing delegated nursing tasks
506.6 and must have an appropriate licensed health professional available if performing other
506.7 delegated services such as therapies.

506.8 (c) The appropriate contact person must be readily available either in person, by
506.9 telephone, or by other means to the staff at times when the staff is providing services.

506.10 Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform
506.11 basic home care services must be supervised periodically where the services are being
506.12 provided to verify that the work is being performed competently and to identify problems
506.13 and solutions to address issues relating to the staff's ability to provide the services. The
506.14 supervision of the unlicensed personnel must be done by staff of the home care provider
506.15 having the authority, skills, and ability to provide the supervision of unlicensed personnel
506.16 and who can implement changes as needed, and train staff.

506.17 (b) Supervision includes direct observation of unlicensed personnel while the
506.18 unlicensed personnel are providing the services and may also include indirect methods of
506.19 gaining input such as gathering feedback from the client. Supervisory review of staff must
506.20 be provided at a frequency based on the staff person's competency and performance.

506.21 (c) For an individual who is licensed as a home care provider, this section does
506.22 not apply.

506.23 Subd. 3. **Supervision of staff providing delegated nursing or therapy home**
506.24 **care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be
506.25 supervised by an appropriate licensed health professional or a registered nurse periodically
506.26 where the services are being provided to verify that the work is being performed
506.27 competently and to identify problems and solutions related to the staff person's ability to
506.28 perform the tasks. Supervision of staff performing medication or treatment administration
506.29 shall be provided by a registered nurse or appropriate licensed health professional and
506.30 must include observation of the staff administering the medication or treatment and the
506.31 interaction with the client.

506.32 (b) The direct supervision of staff performing delegated tasks must be provided
506.33 within 30 days after the individual begins working for the home care provider and
506.34 thereafter as needed based on performance. This requirement also applies to staff who
506.35 have not performed delegated tasks for one year or longer.

507.1 Subd. 4. **Documentation.** A home care provider must retain documentation of
507.2 supervision activities in the personnel records.

507.3 Subd. 5. **Exemption.** This section does not apply to an individual licensed under
507.4 sections 144A.43 to 144A.4798.

507.5 **Sec. 26. [144A.4798] EMPLOYEE HEALTH STATUS.**

507.6 Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider
507.7 must establish and maintain a TB prevention and control program based on the most
507.8 current guidelines issued by the Centers for Disease Control and Prevention (CDC).
507.9 Components of a TB prevention and control program include screening all staff providing
507.10 home care services, both paid and unpaid, at the time of hire for active TB disease and
507.11 latent TB infection, and developing and implementing a written TB infection control plan.
507.12 The commissioner shall make the most recent CDC standards available to home care
507.13 providers on the department's Web site.

507.14 Subd. 2. **Communicable diseases.** A home care provider must follow
507.15 current federal or state guidelines for prevention, control, and reporting of human
507.16 immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other
507.17 communicable diseases as defined in Minnesota Rules, part 4605.7040.

507.18 **Sec. 27. [144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE**
507.19 **PROVIDER ADVISORY COUNCIL.**

507.20 Subdivision 1. **Membership.** The commissioner of health shall appoint eight
507.21 persons to a home care provider advisory council consisting of the following:

507.22 (1) three public members as defined in section 214.02 who shall be either persons
507.23 who are currently receiving home care services or have family members receiving home
507.24 care services, or persons who have family members who have received home care services
507.25 within five years of the application date;

507.26 (2) three Minnesota home care licensees representing basic and comprehensive
507.27 levels of licensure who may be a managerial official, an administrator, a supervising
507.28 registered nurse, or an unlicensed personnel performing home care tasks;

507.29 (3) one member representing the Minnesota Board of Nursing; and

507.30 (4) one member representing the ombudsman for long-term care.

507.31 Subd. 2. **Organizations and meetings.** The advisory council shall be organized
507.32 and administered under section 15.059 with per diems and costs paid within the limits of
507.33 available appropriations. Meetings will be held quarterly and hosted by the department.

508.1 Subcommittees may be developed as necessary by the commissioner. Advisory council
508.2 meetings are subject to the Open Meeting Law under chapter 13D.

508.3 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide
508.4 advice regarding regulations of Department of Health licensed home care providers in
508.5 this chapter such as:

508.6 (1) advice to the commissioner regarding community standards for home care
508.7 practices;

508.8 (2) advice to the commissioner on enforcement of licensing standards and whether
508.9 certain disciplinary actions are appropriate;

508.10 (3) advice to the commissioner about ways of distributing information to licensees
508.11 and consumers of home care;

508.12 (4) advice to the commissioner about training standards;

508.13 (5) identify emerging issues and opportunities in the home care field, including the
508.14 use of technology in home and telehealth capabilities; and

508.15 (6) perform other duties as directed by the commissioner.

508.16 Sec. 28. **[144A.481] HOME CARE LICENSING IMPLEMENTATION FOR**
508.17 **NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

508.18 Subdivision 1. **Temporary home care licenses and changes of ownership.** (a)
508.19 Beginning January 1, 2014, all temporary license applicants must apply for either a
508.20 temporary basic or comprehensive home care license.

508.21 (b) Temporary home care licenses issued beginning January 1, 2014, shall be
508.22 issued according to sections 144A.43 to 144A.4798, and the fees in section 144A.472.

508.23 Temporary licensees must comply with the requirements of this chapter.

508.24 (c) No temporary license applications will be accepted nor temporary licenses issued
508.25 between December 1, 2013, and December 31, 2013.

508.26 (d) Beginning October 1, 2013, changes in ownership applications will require
508.27 payment of the new fees listed in section 144A.472. Providers who are providing
508.28 nursing, delegated nursing, or professional health care services, must submit the fee for
508.29 comprehensive home care providers, and all other providers must submit the fee for basic
508.30 home care providers as provided in section 144A.472. Change of ownership applicants will
508.31 be issued a new home care license based on the licensure law in effect on June 30, 2013.

508.32 Subd. 2. **Current home care licensees with licenses prior to July 1, 2013.** (a)
508.33 Beginning July 1, 2014, department licensed home care providers must apply for either
508.34 the basic or comprehensive home care license on their regularly scheduled renewal date.

509.1 (b) By June 30, 2015, all home care providers must either have a basic or
509.2 comprehensive home care license or temporary license.

509.3 Subd. 3. **Renewal application of home care licensure during transition period.**

509.4 (a) Renewal and change of ownership applications of home care licenses issued beginning
509.5 July 1, 2014, will be issued according to sections 144A.43 to 144A.4798 and, upon license
509.6 renewal or issuance of a new license for a change of ownership, providers must comply
509.7 with sections 144A.43 to 144A.4798. Prior to renewal, providers must comply with the
509.8 home care licensure law in effect on June 30, 2013.

509.9 (b) The fees charged for licenses renewed between July 1, 2014, and June 30, 2016,
509.10 shall be the lesser of 200 percent or \$1,000, except where the 200 percent or \$1,000
509.11 increase exceeds the actual renewal fee charged, with a maximum renewal fee of \$6,625.

509.12 (c) For fiscal year 2014 only, the fees for providers with revenues greater than
509.13 \$25,000 and no more than \$100,000 will be \$313 and for providers with revenues no
509.14 more than \$25,000 the fee will be \$125.

509.15 Sec. 29. **[144A.482] REGISTRATION OF HOME MANAGEMENT**
509.16 **PROVIDERS.**

509.17 (a) For purposes of this section, a home management provider is a person or
509.18 organization that provides at least two of the following services: housekeeping, meal
509.19 preparation, and shopping to a person who is unable to perform these activities due to
509.20 illness, disability, or physical condition.

509.21 (b) A person or organization that provides only home management services may not
509.22 operate in the state without a current certificate of registration issued by the commissioner
509.23 of health. To obtain a certificate of registration, the person or organization must annually
509.24 submit to the commissioner the name, mailing and physical addresses, e-mail address, and
509.25 telephone number of the person or organization and a signed statement declaring that the
509.26 person or organization is aware that the home care bill of rights applies to their clients and
509.27 that the person or organization will comply with the home care bill of rights provisions
509.28 contained in section 144A.44. A person or organization applying for a certificate must
509.29 also provide the name, business address, and telephone number of each of the persons
509.30 responsible for the management or direction of the organization.

509.31 (c) The commissioner shall charge an annual registration fee of \$20 for persons and
509.32 \$50 for organizations. The registration fee shall be deposited in the state treasury and
509.33 credited to the state government special revenue fund.

509.34 (d) A home care provider that provides home management services and other home
509.35 care services must be licensed, but licensure requirements other than the home care bill of

510.1 rights do not apply to those employees or volunteers who provide only home management
510.2 services to clients who do not receive any other home care services from the provider.

510.3 A licensed home care provider need not be registered as a home management service
510.4 provider but must provide an orientation on the home care bill of rights to its employees
510.5 or volunteers who provide home management services.

510.6 (e) An individual who provides home management services under this section must,
510.7 within 120 days after beginning to provide services, attend an orientation session approved
510.8 by the commissioner that provides training on the home care bill of rights and an orientation
510.9 on the aging process and the needs and concerns of elderly and disabled persons.

510.10 (f) The commissioner may suspend or revoke a provider's certificate of registration
510.11 or assess fines for violation of the home care bill of rights. Any fine assessed for a
510.12 violation of the home care bill of rights by a provider registered under this section shall be
510.13 in the amount established in the licensure rules for home care providers. As a condition
510.14 of registration, a provider must cooperate fully with any investigation conducted by the
510.15 commissioner, including providing specific information requested by the commissioner on
510.16 clients served and the employees and volunteers who provide services. Fines collected
510.17 under this paragraph shall be deposited in the state treasury and credited to the fund
510.18 specified in the statute or rule in which the penalty was established.

510.19 (g) The commissioner may use any of the powers granted in sections 144A.43 to
510.20 144A.4798 to administer the registration system and enforce the home care bill of rights
510.21 under this section.

510.22 **Sec. 30. [144A.483] AGENCY QUALITY IMPROVEMENT PROGRAM.**

510.23 Subdivision 1. **Annual legislative report on home care licensing.** The
510.24 commissioner shall establish a quality improvement program for the home care survey
510.25 and home care complaint investigation processes. The commissioner shall submit to the
510.26 legislature an annual report, beginning October 1, 2015, and each October 1 thereafter.
510.27 Each report will review the previous state fiscal year of home care licensing and regulatory
510.28 activities. The report must include, but is not limited to, an analysis of:

510.29 (1) the number of FTE's in the Division of Compliance Monitoring, including the
510.30 Office of Health Facility Complaints units assigned to home care licensing, survey,
510.31 investigation and enforcement process;

510.32 (2) numbers of and descriptive information about licenses issued, complaints
510.33 received and investigated, including allegations made and correction orders issued,
510.34 surveys completed and timelines, and correction order reconsiderations and results;

511.1 (3) descriptions of emerging trends in home care provision and areas of concern
511.2 identified by the department in its regulation of home care providers;

511.3 (4) information and data regarding performance improvement projects underway
511.4 and planned by the commissioner in the area of home care surveys; and

511.5 (5) work of the Department of Health Home Care Advisory Council.

511.6 Subd. 2. **Study of correction order appeal process.** Starting July 1, 2015, the
511.7 commissioner shall study whether to add a correction order appeal process conducted by
511.8 an independent reviewer such as an administrative law judge or other office and submit a
511.9 report to the legislature by February 1, 2016. The commissioner shall review home care
511.10 regulatory systems in other states as part of that study. The commissioner shall consult
511.11 with the home care providers and representatives.

511.12 Sec. 31. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
511.13 **AND COMMUNITY-BASED SERVICES.**

511.14 (a) The Department of Health Compliance Monitoring Division and the Department
511.15 of Human Services Licensing Division shall jointly develop an integrated licensing system
511.16 for providers of both home care services subject to licensure under Minnesota Statutes,
511.17 chapter 144A, and for home and community-based services subject to licensure under
511.18 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

511.19 (1) require only one license of any provider of services under Minnesota Statutes,
511.20 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

511.21 (2) promote quality services that recognize a person's individual needs and protect
511.22 the person's health, safety, rights, and well-being;

511.23 (3) promote provider accountability through application requirements, compliance
511.24 inspections, investigations, and enforcement actions;

511.25 (4) reference other applicable requirements in existing state and federal laws,
511.26 including the federal Affordable Care Act;

511.27 (5) establish internal procedures to facilitate ongoing communications between the
511.28 agencies, and with providers and services recipients about the regulatory activities;

511.29 (6) create a link between the agency Web sites so that providers and the public can
511.30 access the same information regardless of which Web site is accessed initially; and

511.31 (7) collect data on identified outcome measures as necessary for the agencies to
511.32 report to the Centers for Medicare and Medicaid Services.

511.33 (b) The joint recommendations for legislative changes to implement the integrated
511.34 licensing system are due to the legislature by February 15, 2014.

512.1 (c) Before implementation of the integrated licensing system, providers licensed as
512.2 home care providers under Minnesota Statutes, chapter 144A, may also provide home
512.3 and community-based services subject to licensure under Minnesota Statutes, chapter
512.4 245D, without obtaining a home and community-based services license under Minnesota
512.5 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
512.6 apply to these providers:

512.7 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
512.8 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

512.9 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
512.10 enforced by the Department of Health under the enforcement authority set forth in
512.11 Minnesota Statutes, section 144A.475; and

512.12 (3) the Department of Health will provide information to the Department of Human
512.13 Services about each provider licensed under this section, including the provider's license
512.14 application, licensing documents, inspections, information about complaints received, and
512.15 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

512.16 **Sec. 32. STUDY OF CORRECTION ORDER APPEAL PROCESS.**

512.17 Beginning July 1, 2015, the commissioner of health shall study whether to use
512.18 a correction order appeal process conducted by an independent reviewer, such as
512.19 an administrative law judge or other office. The commissioner shall review home
512.20 care regulatory systems in other states and consult with the home care providers and
512.21 representatives. By February 1, 2016, the commissioner shall submit a report to the chairs
512.22 and ranking minority members of the committees of the legislature with jurisdiction over
512.23 health and human services and judiciary issues with any recommendations regarding
512.24 an independent appeal process.

512.25 **Sec. 33. REPEALER.**

512.26 (a) Minnesota Statutes 2012, sections 144A.46; and 144A.461, are repealed.

512.27 (b) Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008;
512.28 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040;
512.29 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
512.30 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170;
512.31 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240;
512.32 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830;
512.33 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870;
512.34 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; and 4669.0050, are repealed.

513.1 Sec. 34. **EFFECTIVE DATE.**

513.2 This article is effective the day following final enactment.

513.3 **ARTICLE 12**

513.4 **HEALTH DEPARTMENT**

513.5 Section 1. Minnesota Statutes 2012, section 16A.724, subdivision 2, is amended to read:

513.6 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available
513.7 resources in the health care access fund exceed expenditures in that fund, effective for
513.8 the biennium beginning July 1, 2007, the commissioner of management and budget shall
513.9 transfer the excess funds from the health care access fund to the general fund on June 30
513.10 of each year, provided that the amount transferred in any fiscal biennium shall not exceed
513.11 \$96,000,000. The purpose of this transfer is to meet the rate increase required under Laws
513.12 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

513.13 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and,
513.14 if necessary, the commissioner shall reduce these transfers from the health care access
513.15 fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary,
513.16 transfer sufficient funds from the general fund to the health care access fund to meet
513.17 annual MinnesotaCare expenditures.

513.18 (c) Notwithstanding section 295.581, to the extent available resources in the health
513.19 care access fund exceed expenditures in that fund after the transfer required in paragraph
513.20 (a), effective for the biennium beginning July 1, 2013, the commissioner of management
513.21 and budget shall transfer \$1,000,000 each fiscal year from the health access fund to
513.22 the medical education and research costs fund established under section 62J.692, for
513.23 distribution under section 62J.692, subdivision 4, paragraph (c).

513.24 Sec. 2. Minnesota Statutes 2012, section 43A.23, is amended by adding a subdivision
513.25 to read:

513.26 Subd. 4. **Coverage for autism spectrum disorders.** For participants in the state
513.27 employee group insurance program, the commissioner of management and budget must
513.28 administer the identical benefit as is required under section 62A.3094.

513.29 **EFFECTIVE DATE.** This section is effective January 1, 2016, or the date a
513.30 collective bargaining agreement or compensation plan that includes changes to this section
513.31 is approved under Minnesota Statutes, section 3.855, whichever is earlier.

513.32 Sec. 3. **[62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

514.1 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
514.2 paragraphs (b) to (d) have the meanings given.

514.3 (b) "Autism spectrum disorders" means the conditions as determined by criteria
514.4 set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental
514.5 Disorders of the American Psychiatric Association.

514.6 (c) "Medically necessary care" means health care services appropriate, in terms of
514.7 type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic
514.8 testing and preventative services. Medically necessary care must be consistent with
514.9 generally accepted practice parameters as determined by physicians and licensed
514.10 psychologists who typically manage patients who have autism spectrum disorders.

514.11 (d) "Mental health professional" means a mental health professional as defined in
514.12 section 245.4871, subdivision 27, clause (1), (2), (3), (4), or (6), who has training and
514.13 expertise in autism spectrum disorder and child development.

514.14 Subd. 2. **Coverage required.** (a) A health plan issued to a large employer, as
514.15 defined in section 62Q.18, subdivision 1, must provide coverage for the diagnosis,
514.16 evaluation, multidisciplinary assessment, and medically necessary care of children under
514.17 18 with autism spectrum disorders, including but not limited to the following:

514.18 (1) early intensive behavioral and developmental therapy based in behavioral and
514.19 developmental science, including, but not limited to, all types of applied behavior analysis,
514.20 intensive early intervention behavior therapy, and intensive behavior intervention;

514.21 (2) neurodevelopmental and behavioral health treatments and management;

514.22 (3) speech therapy;

514.23 (4) occupational therapy;

514.24 (5) physical therapy; and

514.25 (6) medications.

514.26 (b) The diagnosis, evaluation, and assessment must include an assessment of the
514.27 child's developmental skills, functional behavior, needs, and capacities.

514.28 (c) The coverage required under this subdivision must include treatment that is in
514.29 accordance with an individualized treatment plan prescribed by the enrollee's treating
514.30 physician or mental health professional.

514.31 (d) A health carrier may not refuse to renew or reissue, or otherwise terminate or
514.32 restrict, coverage of an individual solely because the individual is diagnosed with an
514.33 autism spectrum disorder.

514.34 (e) A health carrier may request an updated treatment plan only once every six
514.35 months, unless the health carrier and the treating physician or mental health professional
514.36 agree that a more frequent review is necessary due to emerging circumstances.

515.1 (g) An independent progress evaluation conducted by a mental health professional
515.2 with expertise and training in autism spectrum disorder and child development must be
515.3 completed to determine if progress toward function and generalizable gains, as determined
515.4 in the treatment plan, is being made.

515.5 Subd. 3. **No effect on other law.** Nothing in this section limits the coverage
515.6 required under section 62Q.47.

515.7 Subd. 4. **State health care programs.** This section does not affect benefits available
515.8 under the medical assistance and MinnesotaCare programs and does not limit, restrict, or
515.9 otherwise reduce coverage under these programs.

515.10 **EFFECTIVE DATE.** This section is effective for health plans offered, sold, issued,
515.11 or renewed on or after January 1, 2014.

515.12 Sec. 4. Minnesota Statutes 2012, section 62J.692, subdivision 1, is amended to read:

515.13 Subdivision 1. **Definitions.** For purposes of this section, the following definitions
515.14 apply:

515.15 (a) "Accredited clinical training" means the clinical training provided by a medical
515.16 education program that is accredited through an organization recognized by the Department
515.17 of Education, the Centers for Medicare and Medicaid Services, or another national body
515.18 who reviews the accrediting organizations for multiple disciplines and whose standards
515.19 for recognizing accrediting organizations are reviewed and approved by the commissioner
515.20 of health ~~in consultation with the Medical Education and Research Advisory Committee.~~

515.21 (b) "Commissioner" means the commissioner of health.

515.22 (c) "Clinical medical education program" means the accredited clinical training of
515.23 physicians (medical students and residents), doctor of pharmacy practitioners, doctors
515.24 of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified
515.25 registered nurse anesthetists, nurse practitioners, and certified nurse midwives), ~~and~~
515.26 physician assistants, dental therapists and advanced dental therapists, psychologists,
515.27 clinical social workers, community paramedics, and community health workers.

515.28 (d) "Sponsoring institution" means a hospital, school, or consortium located in
515.29 Minnesota that sponsors and maintains primary organizational and financial responsibility
515.30 for a clinical medical education program in Minnesota and which is accountable to the
515.31 accrediting body.

515.32 (e) "Teaching institution" means a hospital, medical center, clinic, or other
515.33 organization that conducts a clinical medical education program in Minnesota.

515.34 (f) "Trainee" means a student or resident involved in a clinical medical education
515.35 program.

516.1 (g) "Eligible trainee FTE's" means the number of trainees, as measured by full-time
516.2 equivalent counts, that are at training sites located in Minnesota with currently active
516.3 medical assistance enrollment status and a National Provider Identification (NPI) number
516.4 where training occurs in either an inpatient or ambulatory patient care setting and where
516.5 the training is funded, in part, by patient care revenues. Training that occurs in nursing
516.6 facility settings is not eligible for funding under this section.

516.7 Sec. 5. Minnesota Statutes 2012, section 62J.692, subdivision 3, is amended to read:

516.8 Subd. 3. **Application process.** (a) A clinical medical education program conducted
516.9 in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners,
516.10 dentists, chiropractors, ~~or~~ physician assistants is, dental therapists and advanced dental
516.11 therapists, psychologists, clinical social workers, community paramedics, or community
516.12 health workers are eligible for funds under subdivision 4 if the program:

516.13 (1) is funded, in part, by patient care revenues;

516.14 (2) occurs in patient care settings that face increased financial pressure as a result
516.15 of competition with nonteaching patient care entities; and

516.16 (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

516.17 (b) A clinical medical education program for advanced practice nursing is eligible for
516.18 funds under subdivision 4 if the program meets the eligibility requirements in paragraph
516.19 (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health
516.20 Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges
516.21 and Universities system or members of the Minnesota Private College Council.

516.22 (c) Applications must be submitted to the commissioner by a sponsoring institution
516.23 on behalf of an eligible clinical medical education program and must be received by
516.24 October 31 of each year for distribution in the following year. An application for funds
516.25 must contain the following information:

516.26 (1) the official name and address of the sponsoring institution and the official
516.27 name and site address of the clinical medical education programs on whose behalf the
516.28 sponsoring institution is applying;

516.29 (2) the name, title, and business address of those persons responsible for
516.30 administering the funds;

516.31 (3) for each clinical medical education program for which funds are being sought;
516.32 the type and specialty orientation of trainees in the program; the name, site address, and
516.33 medical assistance provider number and national provider identification number of each
516.34 training site used in the program; the federal tax identification number of each training site

517.1 used in the program, where available; the total number of trainees at each training site; and
517.2 the total number of eligible trainee FTEs at each site; and

517.3 (4) other supporting information the commissioner deems necessary to determine
517.4 program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the
517.5 equitable distribution of funds.

517.6 (d) An application must include the information specified in clauses (1) to (3) for
517.7 each clinical medical education program on an annual basis for three consecutive years.
517.8 After that time, an application must include the information specified in clauses (1) to (3)
517.9 when requested, at the discretion of the commissioner:

517.10 (1) audited clinical training costs per trainee for each clinical medical education
517.11 program when available or estimates of clinical training costs based on audited financial
517.12 data;

517.13 (2) a description of current sources of funding for clinical medical education costs,
517.14 including a description and dollar amount of all state and federal financial support,
517.15 including Medicare direct and indirect payments; and

517.16 (3) other revenue received for the purposes of clinical training.

517.17 (e) An applicant that does not provide information requested by the commissioner
517.18 shall not be eligible for funds for the current funding cycle.

517.19 Sec. 6. Minnesota Statutes 2012, section 62J.692, subdivision 4, is amended to read:

517.20 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the
517.21 available medical education funds to all qualifying applicants based on ~~a distribution~~
517.22 ~~formula that reflects a summation of two factors:~~

517.23 ~~(1) a public program volume factor, which is determined by the total volume of~~
517.24 ~~public program revenue received by each training site as a percentage of all public~~
517.25 ~~program revenue received by all training sites in the fund pool; and~~

517.26 ~~(2) a supplemental public program volume factor, which is determined by providing~~
517.27 ~~a supplemental payment of 20 percent of each training site's grant to training sites whose~~
517.28 ~~public program revenue accounted for at least 0.98 percent of the total public program~~
517.29 ~~revenue received by all eligible training sites. Grants to training sites whose public~~
517.30 ~~program revenue accounted for less than 0.98 percent of the total public program revenue~~
517.31 ~~received by all eligible training sites shall be reduced by an amount equal to the total~~
517.32 ~~value of the supplemental payment.~~

517.33 Public program revenue for the distribution formula includes revenue from medical
517.34 assistance, prepaid medical assistance, general assistance medical care, and prepaid
517.35 general assistance medical care. Training sites that receive no public program revenue

518.1 are ineligible for funds available under this subdivision. For purposes of determining
 518.2 training-site level grants to be distributed under ~~paragraph (a)~~ this paragraph, total
 518.3 statewide average costs per trainee for medical residents is based on audited clinical
 518.4 training costs per trainee in primary care clinical medical education programs for medical
 518.5 residents. Total statewide average costs per trainee for dental residents is based on
 518.6 audited clinical training costs per trainee in clinical medical education programs for
 518.7 dental students. Total statewide average costs per trainee for pharmacy residents is based
 518.8 on audited clinical training costs per trainee in clinical medical education programs for
 518.9 pharmacy students. Training sites whose training site level grant is less than \$1,000
 518.10 \$5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE
 518.11 eligible trainees, are ineligible for funds available under this subdivision. No training sites
 518.12 shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE
 518.13 across all eligible training sites; grants in excess of this amount will be redistributed to
 518.14 other eligible sites based on the formula described in this paragraph.

518.15 (b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall
 518.16 include a supplemental public program volume factor, which is determined by providing
 518.17 a supplemental payment to training sites whose public program revenue accounted for
 518.18 at least 0.98 percent of the total public program revenue received by all eligible training
 518.19 sites. The supplemental public program volume factor shall be equal to ten percent of each
 518.20 training sites grant for funds distributed in fiscal year 2014 and for funds distributed in
 518.21 fiscal year 2015. Grants to training sites whose public program revenue accounted for less
 518.22 than 0.98 percent of the total public program revenue received by all eligible training sites
 518.23 shall be reduced by an amount equal to the total value of the supplemental payment. For
 518.24 fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public
 518.25 program volume factor as described in paragraph (a).

518.26 (c) Of available medical education funds, \$1,000,000 shall be distributed each year
 518.27 for grants to family medicine residency programs located outside of the seven-county
 518.28 metropolitan area, as defined in section 473.121, subdivision 4, focused on education and
 518.29 training of family medicine physicians to serve communities outside the metropolitan area.
 518.30 To be eligible for a grant under this paragraph, a family medicine residency program must
 518.31 demonstrate that over the most recent three calendar years, at least 25 percent of its residents
 518.32 practice in Minnesota communities outside of the metropolitan area. Grant funds must be
 518.33 allocated proportionally based on the number of residents per eligible residency program.

518.34 ~~(b)~~ (d) Funds distributed shall not be used to displace current funding appropriations
 518.35 from federal or state sources.

519.1 ~~(e)~~ (e) Funds shall be distributed to the sponsoring institutions indicating the amount
519.2 to be distributed to each of the sponsor's clinical medical education programs based on
519.3 the criteria in this subdivision and in accordance with the commissioner's approval letter.
519.4 Each clinical medical education program must distribute funds allocated under ~~paragraph~~
519.5 paragraphs (a) and (b) to the training sites as specified in the commissioner's approval
519.6 letter. Sponsoring institutions, which are accredited through an organization recognized
519.7 by the Department of Education or the Centers for Medicare and Medicaid Services, may
519.8 contract directly with training sites to provide clinical training. To ensure the quality of
519.9 clinical training, those accredited sponsoring institutions must:

519.10 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical
519.11 training conducted at sites; and

519.12 (2) take necessary action if the contract requirements are not met. Action may include
519.13 the withholding of payments under this section or the removal of students from the site.

519.14 ~~(d)~~ (f) Use of funds is limited to expenses related to clinical training program costs
519.15 for eligible programs.

519.16 (g) Any funds not distributed in accordance with the commissioner's approval letter
519.17 must be returned to the medical education and research fund within 30 days of receiving
519.18 notice from the commissioner. The commissioner shall distribute returned funds to the
519.19 appropriate training sites in accordance with the commissioner's approval letter.

519.20 ~~(e)~~ (h) A maximum of \$150,000 of the funds dedicated to the commissioner
519.21 under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for
519.22 administrative expenses associated with implementing this section.

519.23 Sec. 7. Minnesota Statutes 2012, section 62J.692, subdivision 5, is amended to read:

519.24 Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section
519.25 must sign and submit a medical education grant verification report (GVR) to verify that
519.26 the correct grant amount was forwarded to each eligible training site. If the sponsoring
519.27 institution fails to submit the GVR by the stated deadline, or to request and meet
519.28 the deadline for an extension, the sponsoring institution is required to return the full
519.29 amount of funds received to the commissioner within 30 days of receiving notice from
519.30 the commissioner. The commissioner shall distribute returned funds to the appropriate
519.31 training sites in accordance with the commissioner's approval letter.

519.32 (b) The reports must provide verification of the distribution of the funds and must
519.33 include:

519.34 (1) the total number of eligible trainee FTEs in each clinical medical education
519.35 program;

520.1 (2) the name of each funded program and, for each program, the dollar amount
520.2 distributed to each training site and a training site expenditure report;

520.3 (3) documentation of any discrepancies between the initial grant distribution notice
520.4 included in the commissioner's approval letter and the actual distribution;

520.5 (4) a statement by the sponsoring institution stating that the completed grant
520.6 verification report is valid and accurate; and

520.7 (5) other information the commissioner, ~~with advice from the advisory committee,~~
520.8 deems appropriate to evaluate the effectiveness of the use of funds for medical education.

520.9 (c) ~~By February 15 of~~ Each year, the commissioner, ~~with advice from the~~
520.10 ~~advisory committee,~~ shall provide an annual summary report to the legislature on the
520.11 implementation of this section.

520.12 Sec. 8. Minnesota Statutes 2012, section 62J.692, subdivision 9, is amended to read:

520.13 Subd. 9. **Review of eligible providers.** The commissioner ~~and the Medical~~
520.14 ~~Education and Research Costs Advisory Committee~~ may review provider groups included
520.15 in the definition of a clinical medical education program to assure that the distribution
520.16 of the funds continue to be consistent with the purpose of this section. The results of
520.17 any such reviews must be reported to the chairs and ranking minority members of the
520.18 legislative committees with jurisdiction over health care policy and finance.

520.19 Sec. 9. Minnesota Statutes 2012, section 62J.692, is amended by adding a subdivision
520.20 to read:

520.21 Subd. 11. **Distribution of funds.** If federal approval is not received for the formula
520.22 described in subdivision 4, paragraphs (a) and (b), 100 percent of available medical
520.23 education and research funds shall be distributed based on a distribution formula that
520.24 reflects as summation of two factors:

520.25 (1) a public program volume factor, that is determined by the total volume of public
520.26 program revenue received by each training site as a percentage of all public program
520.27 revenue received by all training sites in the fund pool; and

520.28 (2) a supplemental public program volume factor, that is determined by providing a
520.29 supplemental payment of 20 percent of each training site's grant to training sites whose
520.30 public program revenue accounted for a least 0.98 percent of the total public program
520.31 revenue received by all eligible training sites. Grants to training sites whose public
520.32 program revenue accounted for less than 0.98 percent of the total public program revenue
520.33 received by all eligible training sites shall be reduced by an amount equal to the total
520.34 value of the supplemental payment.

521.1 Sec. 10. Minnesota Statutes 2012, section 62Q.19, subdivision 1, is amended to read:

521.2 Subdivision 1. **Designation.** (a) The commissioner shall designate essential
521.3 community providers. The criteria for essential community provider designation shall be
521.4 the following:

521.5 (1) a demonstrated ability to integrate applicable supportive and stabilizing services
521.6 with medical care for uninsured persons and high-risk and special needs populations,
521.7 underserved, and other special needs populations; and

521.8 (2) a commitment to serve low-income and underserved populations by meeting the
521.9 following requirements:

521.10 (i) has nonprofit status in accordance with chapter 317A;

521.11 (ii) has tax-exempt status in accordance with the Internal Revenue Service Code,
521.12 section 501(c)(3);

521.13 (iii) charges for services on a sliding fee schedule based on current poverty income
521.14 guidelines; and

521.15 (iv) does not restrict access or services because of a client's financial limitation;

521.16 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a
521.17 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal
521.18 government, an Indian health service unit, or a community health board as defined in
521.19 chapter 145A;

521.20 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina
521.21 bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling
521.22 conditions;

521.23 (5) a sole community hospital. For these rural hospitals, the essential community
521.24 provider designation applies to all health services provided, including both inpatient and
521.25 outpatient services. For purposes of this section, "sole community hospital" means a
521.26 rural hospital that:

521.27 (i) is eligible to be classified as a sole community hospital according to Code
521.28 of Federal Regulations, title 42, section 412.92, or is located in a community with a
521.29 population of less than 5,000 and located more than 25 miles from a like hospital currently
521.30 providing acute short-term services;

521.31 (ii) has experienced net operating income losses in two of the previous three
521.32 most recent consecutive hospital fiscal years for which audited financial information is
521.33 available; and

521.34 (iii) consists of 40 or fewer licensed beds; ~~or~~

521.35 (6) a birth center licensed under section 144.615; or

522.1 (7) a hospital and affiliated specialty clinics that predominantly serve patients who
522.2 are under 21 years of age and meet the following criteria:

522.3 (i) provide intensive specialty pediatric services that are routinely provided in fewer
522.4 than five hospitals in the state; and

522.5 (ii) serve children from at least half of the counties in the state.

522.6 (b) Prior to designation, the commissioner shall publish the names of all applicants
522.7 in the State Register. The public shall have 30 days from the date of publication to submit
522.8 written comments to the commissioner on the application. No designation shall be made
522.9 by the commissioner until the 30-day period has expired.

522.10 (c) The commissioner may designate an eligible provider as an essential community
522.11 provider for all the services offered by that provider or for specific services designated by
522.12 the commissioner.

522.13 (d) For the purpose of this subdivision, supportive and stabilizing services include at
522.14 a minimum, transportation, child care, cultural, and linguistic services where appropriate.

522.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

522.16 Sec. 11. Minnesota Statutes 2012, section 103I.005, is amended by adding a
522.17 subdivision to read:

522.18 Subd. 1a. **Bored geothermal heat exchanger.** "Bored geothermal heat exchanger"
522.19 means an earth-coupled heating or cooling device consisting of a sealed closed-loop
522.20 pipng system installed in a boring in the ground to transfer heat to or from the surrounding
522.21 earth with no discharge.

522.22 Sec. 12. Minnesota Statutes 2012, section 103I.521, is amended to read:

522.23 **103I.521 FEES DEPOSITED WITH COMMISSIONER OF MANAGEMENT**
522.24 **AND BUDGET.**

522.25 Unless otherwise specified, fees collected for licenses or registration by the
522.26 commissioner under this chapter shall be deposited in the state treasury and credited to
522.27 the state government special revenue fund.

522.28 Sec. 13. Minnesota Statutes 2012, section 144.123, subdivision 1, is amended to read:

522.29 Subdivision 1. **Who must pay.** Except for the limitation contained in this section,
522.30 the commissioner of health ~~shall charge a handling fee~~ may enter into a contractual
522.31 agreement to recover costs incurred for analysis for diagnostic purposes for each specimen
522.32 submitted to the Department of Health ~~for analysis for diagnostic purposes~~ by any hospital,

523.1 private laboratory, private clinic, or physician. ~~No fee shall be charged to any entity which~~
523.2 ~~receives direct or indirect financial assistance from state or federal funds administered by~~
523.3 ~~the Department of Health, including any public health department, nonprofit community~~
523.4 ~~clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged~~ The
523.5 commissioner shall not charge for any biological materials submitted to the Department
523.6 of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological
523.7 materials requested by the department to gather information for disease prevention or
523.8 control purposes. The commissioner of health may establish other exceptions to the
523.9 handling fee as may be necessary to protect the public's health. ~~All fees collected pursuant~~
523.10 ~~to this section shall be deposited in the state treasury and credited to the state government~~
523.11 ~~special revenue fund.~~ Funds generated in a contractual agreement made pursuant to this
523.12 section shall be deposited in a special account and are appropriated to the commissioner
523.13 for purposes of providing the services specified in the contracts. All such contractual
523.14 agreements shall be processed in accordance with the provisions of chapter 16C.

523.15 **EFFECTIVE DATE.** This section is effective July 1, 2014.

523.16 Sec. 14. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:

523.17 Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative
523.18 officer or other person in charge of each institution caring for infants 28 days or less
523.19 of age, (2) the person required in pursuance of the provisions of section 144.215, to
523.20 register the birth of a child, or (3) the nurse midwife or midwife in attendance at the
523.21 birth, to arrange to have administered to every infant or child in its care tests for heritable
523.22 and congenital disorders according to subdivision 2 and rules prescribed by the state
523.23 commissioner of health.

523.24 (b) ~~Testing and the, recording and of test results, reporting of test results, and~~
523.25 follow-up of infants with heritable congenital disorders, including hearing loss detected
523.26 through the early hearing detection and intervention program in section 144.966, shall be
523.27 performed at the times and in the manner prescribed by the commissioner of health. The
523.28 ~~commissioner shall charge a fee so that the total of fees collected will approximate the~~
523.29 ~~costs of conducting the tests and implementing and maintaining a system to follow-up~~
523.30 ~~infants with heritable or congenital disorders, including hearing loss detected through the~~
523.31 ~~early hearing detection and intervention program under section 144.966.~~

523.32 (c) ~~The fee is \$101 per specimen. Effective July 1, 2010, the fee shall be increased~~
523.33 ~~to \$106 to support the newborn screening program, including tests administered under~~
523.34 this section and section 144.966, shall be \$135 per specimen. The increased fee amount
523.35 ~~shall be deposited in the general fund. Costs associated with capital expenditures and~~

524.1 ~~the development of new procedures may be prorated over a three-year period when~~
524.2 ~~calculating the amount of the fees.~~ This fee amount shall be deposited in the state treasury
524.3 and credited to the state government special revenue fund.

524.4 (d) The fee to offset the cost of the support services provided under section 144.966,
524.5 subdivision 3a, shall be \$15 per specimen. This fee shall be deposited in the state treasury
524.6 and credited to the general fund.

524.7 Sec. 15. [144.1251] NEWBORN SCREENING FOR CRITICAL CONGENITAL
524.8 HEART DISEASE (CCHD).

524.9 Subdivision 1. **Required testing and reporting.** (a) Each licensed hospital or
524.10 state-licensed birthing center or facility that provides maternity and newborn care services
524.11 shall provide screening for congenital heart disease to all newborns prior to discharge
524.12 using pulse oximetry screening. The screening must occur after the infant is 24 hours old,
524.13 before discharge from the nursery. If discharge occurs before the infant is 24 hours old,
524.14 the screening must occur as close as possible to the time of discharge.

524.15 (b) For premature infants (less than 36 weeks of gestation) and infants admitted to a
524.16 higher-level nursery (special care or intensive care), pulse oximetry must be performed
524.17 when medically appropriate prior to discharge.

524.18 (c) Results of the screening must be reported to the Department of Health.

524.19 Subd. 2. **Implementation.** The Department of Health shall:

524.20 (1) communicate the screening protocol requirements;

524.21 (2) make information and forms available to the hospitals, birthing centers, and other
524.22 facilities that are required to provide the screening, health care providers who provide
524.23 prenatal care and care to newborns, and expectant parents and parents of newborns. The
524.24 information and forms must include screening protocol and reporting requirements and
524.25 parental options;

524.26 (3) provide training to ensure compliance with and appropriate implementation of
524.27 the screening;

524.28 (4) establish the mechanism for the required data collection and reporting of
524.29 screening and follow-up diagnostic results to the Department of Health according to the
524.30 Department of Health's recommendations;

524.31 (5) coordinate the implementation of universal standardized screening;

524.32 (6) act as a resource for providers as the screening program is implemented, and in
524.33 consultation with the Advisory Committee on Heritable and Congenital Disorders, develop
524.34 and implement policies for early medical and developmental intervention services and
524.35 long-term follow-up services for children and their families identified with a CCHD; and

525.1 (7) comply with sections 144.125 to 144.128.

525.2 Sec. 16. Minnesota Statutes 2012, section 144.212, is amended to read:

525.3 **144.212 DEFINITIONS.**

525.4 Subdivision 1. **Scope.** As used in sections 144.211 to 144.227, the following terms
525.5 have the meanings given.

525.6 Subd. 1a. **Amendment.** "Amendment" means completion or correction ~~of~~ made
525.7 to certification items on a vital record: after a certification has been issued or more
525.8 than one year after the event, whichever occurs first, that does not result in a sealed or
525.9 replaced record.

525.10 Subd. 1b. **Authorized representative.** "Authorized representative" means an agent
525.11 designated in a written and witnessed statement signed by the subject of the record or
525.12 other qualified applicant.

525.13 Subd. 1c. **Certification item.** "Certification item" means all individual items
525.14 appearing on a certificate of birth and the demographic and legal items on a certificate
525.15 of death.

525.16 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

525.17 Subd. 2a. **Correction.** "Correction" means a change made to a noncertification
525.18 item, including information collected for medical and statistical purposes. A correction
525.19 also means a change to a certification item within one year of the event provided that no
525.20 certification, whether paper or electronic, has been issued.

525.21 Subd. 2b. **Court of competent jurisdiction.** "Court of competent jurisdiction"
525.22 means a court within the United States with jurisdiction over the individual and such other
525.23 individuals that the court deems necessary.

525.24 Subd. 2a 2c. **Delayed registration.** "Delayed registration" means registration of a
525.25 record of birth or death filed one or more years after the date of birth or death.

525.26 Subd. 2d. **Disclosure.** "Disclosure" means to make available or make known
525.27 personally identifiable information contained in a vital record, by any means of
525.28 communication.

525.29 Subd. 3. **File.** "File" means to present a vital record or report for registration to the
525.30 Office of ~~the State Registrar~~ Vital Records and to have the vital record or report accepted
525.31 for registration by the Office of ~~the State Registrar~~ Vital Records.

525.32 Subd. 4. **Final disposition.** "Final disposition" means the burial, interment,
525.33 cremation, removal from the state, or other authorized disposition of a dead body or
525.34 dead fetus.

525.35 Subd. 4a. **Institution.** "Institution" means a public or private establishment that:

526.1 (1) provides inpatient or outpatient medical, surgical, or diagnostic care or treatment;
526.2 or

526.3 (2) provides nursing, custodial, or domiciliary care, or to which persons are
526.4 committed by law.

526.5 Subd. 4b. **Legal representative.** "Legal representative" means a licensed attorney
526.6 representing an individual.

526.7 Subd. 4c. **Local issuance office.** "Local issuance office" means a county
526.8 governmental office authorized by the state registrar to issue certified birth and death
526.9 records.

526.10 Subd. 4d. **Record.** "Record" means a report of a vital event that has been registered
526.11 by the state registrar.

526.12 Subd. 5. **Registration.** "Registration" means the process by which vital records
526.13 are completed, filed, and incorporated into the official records of the Office of the State
526.14 Vital Records Registrar.

526.15 Subd. 6. **State registrar.** "State registrar" means the commissioner of health or a
526.16 designee.

526.17 Subd. 7. **System of vital statistics.** "System of vital statistics" includes the
526.18 registration, collection, preservation, amendment, verification, maintenance of the security
526.19 and integrity of, and certification of vital records, the collection of other reports required
526.20 by sections 144.211 to 144.227, and related activities including the tabulation, analysis,
526.21 publication, and dissemination of vital statistics.

526.22 Subd. 7a. **Verification.** "Verification" means a confirmation of the information on a
526.23 vital record based on the facts contained in a certification.

526.24 Subd. 8. **Vital record.** "Vital record" means a record or report of birth, stillbirth,
526.25 death, marriage, dissolution and annulment, and data related thereto. The birth record is
526.26 not a medical record of the mother or the child.

526.27 Subd. 9. **Vital statistics.** "Vital statistics" means the data derived from records and
526.28 reports of birth, death, fetal death, induced abortion, marriage, dissolution and annulment,
526.29 and related reports.

526.30 ~~Subd. 10. **Local registrar.** "Local registrar" means an individual designated under~~
526.31 ~~section 144.214, subdivision 1, to perform the duties of a local registrar.~~

526.32 Subd. 11. **Consent to disclosure.** "Consent to disclosure" means an affidavit filed
526.33 with the state registrar which sets forth the following information:

526.34 (1) the current name and address of the affiant;

526.35 (2) any previous name by which the affiant was known;

- 527.1 (3) the original and adopted names, if known, of the adopted child whose original
527.2 birth record is to be disclosed;
- 527.3 (4) the place and date of birth of the adopted child;
- 527.4 (5) the biological relationship of the affiant to the adopted child; and
- 527.5 (6) the affiant's consent to disclosure of information from the original birth record of
527.6 the adopted child.

527.7 Sec. 17. Minnesota Statutes 2012, section 144.213, is amended to read:

527.8 **144.213 OFFICE OF THE STATE REGISTRAR VITAL RECORDS.**

527.9 Subdivision 1. **Creation; state registrar; Office of Vital Records.** The
527.10 commissioner shall establish an Office of the ~~State Registrar~~ Vital Records under the
527.11 supervision of the state registrar. ~~The commissioner shall furnish to local registrars the~~
527.12 ~~forms necessary for correct reporting of vital statistics, and shall instruct the local registrars~~
527.13 ~~in the collection and compilation of the data.~~ The commissioner shall promulgate rules for
527.14 the collection, filing, and registering of vital statistics information by the state and local
527.15 ~~registrars~~ registrar, physicians, morticians, and others. Except as otherwise provided in
527.16 sections 144.211 to 144.227, rules previously promulgated by the commissioner relating to
527.17 the collection, filing and registering of vital statistics shall remain in effect until repealed,
527.18 modified or superseded by a rule promulgated by the commissioner.

527.19 Subd. 2. **General duties.** (a) The state registrar shall coordinate the work of
527.20 ~~local registrars to maintain a statewide system of vital statistics. The state registrar is~~
527.21 ~~responsible for the administration and enforcement of sections 144.211 to 144.227; and~~
527.22 ~~shall supervise local registrars in the enforcement of sections 144.211 to 144.227 and the~~
527.23 ~~rules promulgated thereunder.~~ Local issuance offices that fail to comply with the statutes
527.24 or rules or to properly train employees may have their issuance privileges and access to
527.25 the vital records system revoked.

527.26 (b) To preserve vital records the state registrar is authorized to prepare typewritten,
527.27 photographic, electronic or other reproductions of original records and files in the Office
527.28 of Vital Records. The reproductions when certified by the state registrar shall be accepted
527.29 as the original records.

527.30 (c) The state registrar shall also:

527.31 (1) establish, designate, and eliminate offices in the state to aid in the efficient
527.32 issuance of vital records;

527.33 (2) direct the activities of all persons engaged in activities pertaining to the operation
527.34 of the system of vital statistics;

528.1 (3) develop and conduct training programs to promote uniformity of policy and
528.2 procedures throughout the state in matters pertaining to the system of vital statistics; and
528.3 (4) prescribe, furnish, and distribute all forms required by sections 144.211 to
528.4 144.227 and any rules adopted under these sections, and prescribe other means for the
528.5 transmission of data, including electronic submission, that will accomplish the purpose of
528.6 complete, accurate, and timely reporting and registration.

528.7 ~~Subd. 3. **Record-keeping.** To preserve vital records the state registrar is authorized~~
528.8 ~~to prepare typewritten, photographic, electronic or other reproductions of original records~~
528.9 ~~and files in the Office of the State Registrar. The reproductions when certified by the state~~
528.10 ~~or local registrar shall be accepted as the original records.~~

528.11 Sec. 18. [144.2131] SECURITY OF VITAL RECORDS SYSTEM.

528.12 The state registrar shall:

528.13 (1) authenticate all users of the system of vital statistics and document that all users
528.14 require access based on their official duties;

528.15 (2) authorize authenticated users of the system of vital statistics to access specific
528.16 components of the vital statistics systems necessary for their official roles and duties;

528.17 (3) establish separation of duties between staff roles that may be susceptible to fraud
528.18 or misuse and routinely perform audits of staff work for the purposes of identifying fraud
528.19 or misuse within the vital statistics system;

528.20 (4) require that authenticated and authorized users of the system of vital
528.21 statistics maintain a specified level of training related to security and provide written
528.22 acknowledgment of security procedures and penalties;

528.23 (5) validate data submitted for registration through site visits or with independent
528.24 sources outside the registration system at a frequency specified by the state registrar to
528.25 maximize the integrity of the data collected;

528.26 (6) protect personally identifiable information and maintain systems pursuant to
528.27 applicable state and federal laws;

528.28 (7) accept a report of death if the decedent was born in Minnesota or if the decedent
528.29 was a resident of Minnesota from the United States Department of Defense or the United
528.30 States Department of State when the death of a United States citizen occurs outside the
528.31 United States;

528.32 (8) match death records registered in Minnesota and death records provided from
528.33 other jurisdictions to live birth records in Minnesota;

529.1 (9) match death records received from the United States Department of Defense
529.2 or the United States Department of State for deaths of United States citizens occurring
529.3 outside the United States to live birth records in Minnesota;

529.4 (10) work with law enforcement to initiate and provide evidence for active fraud
529.5 investigations;

529.6 (11) provide secure workplace, storage, and technology environments that have
529.7 limited role-based access;

529.8 (12) maintain overt, covert, and forensic security measures for certifications,
529.9 verifications, and automated systems that are part of the vital statistics system; and

529.10 (13) comply with applicable state and federal laws and rules associated with
529.11 information technology systems and related information security requirements.

529.12 Sec. 19. Minnesota Statutes 2012, section 144.215, subdivision 3, is amended to read:

529.13 Subd. 3. **Father's name; child's name.** In any case in which paternity of a child is
529.14 determined by a court of competent jurisdiction, ~~a declaration of parentage is executed~~
529.15 ~~under section 257.34,~~ or a recognition of parentage is executed under section 257.75, the
529.16 name of the father shall be entered on the birth record. If the order of the court declares
529.17 the name of the child, it shall also be entered on the birth record. If the order of the court
529.18 does not declare the name of the child, or there is no court order, then upon the request of
529.19 both parents in writing, the surname of the child shall be defined by both parents.

529.20 Sec. 20. Minnesota Statutes 2012, section 144.215, subdivision 4, is amended to read:

529.21 Subd. 4. **Social Security number registration.** (a) Parents of a child born within
529.22 this state shall give the parents' Social Security numbers to the Office of ~~the State Registrar~~
529.23 Vital Records at the time of filing the birth record, but the numbers shall not appear on
529.24 the certified record.

529.25 (b) The Social Security numbers are classified as private data, ~~as defined in section~~
529.26 ~~13.02, subdivision 12, on individuals,~~ but the Office of ~~the State Registrar~~ Vital Records
529.27 shall provide a Social Security number to the public authority responsible for child support
529.28 services upon request by the public authority for use in the establishment of parentage and
529.29 the enforcement of child support obligations.

529.30 Sec. 21. Minnesota Statutes 2012, section 144.216, subdivision 1, is amended to read:

529.31 Subdivision 1. **Reporting a foundling.** Whoever finds a live born infant of unknown
529.32 parentage shall report within five days to the Office of ~~the State Registrar~~ Vital Records
529.33 such information as the commissioner may by rule require to identify the foundling.

530.1 Sec. 22. Minnesota Statutes 2012, section 144.217, subdivision 2, is amended to read:

530.2 Subd. 2. **Court petition.** If a delayed record of birth is rejected under subdivision
530.3 1, a person may petition the appropriate court in the county in which the birth allegedly
530.4 occurred for an order establishing a record of the date and place of the birth and the
530.5 parentage of the person whose birth is to be registered. The petition shall state:

530.6 (1) that the person for whom a delayed record of birth is sought was born in this state;

530.7 (2) that no record of birth can be found in the Office of ~~the State Registrar~~ Vital
530.8 Records;

530.9 (3) that diligent efforts by the petitioner have failed to obtain the evidence required
530.10 in subdivision 1;

530.11 (4) that the state registrar has refused to register a delayed record of birth; and

530.12 (5) other information as may be required by the court.

530.13 Sec. 23. Minnesota Statutes 2012, section 144.218, subdivision 5, is amended to read:

530.14 Subd. 5. **Replacement of vital records.** Upon the order of a court of this state, upon
530.15 the request of a court of another state, ~~upon the filing of a declaration of parentage under~~
530.16 ~~section 257.34~~, or upon the filing of a recognition of parentage with a the state registrar, a
530.17 replacement birth record must be registered consistent with the findings of the court, ~~the~~
530.18 ~~declaration of parentage~~, or the recognition of parentage.

530.19 Sec. 24. **[144.2181] AMENDMENT AND CORRECTION OF VITAL RECORDS.**

530.20 (a) A vital record registered under sections 144.212 to 144.227 may be amended
530.21 or corrected only according to sections 144.212 to 144.227 and rules adopted by the
530.22 commissioner of health to protect the integrity and accuracy of vital records.

530.23 (b)(1) A vital record that is amended under this section shall indicate that it has been
530.24 amended, except as otherwise provided in this section or by rule.

530.25 (2) Electronic documentation shall be maintained by the state registrar that
530.26 identifies the evidence upon which the amendment or correction was based, the date
530.27 of the amendment or correction, and the identity of the authorized person making the
530.28 amendment or correction.

530.29 (c) Upon receipt of a certified copy of an order of a court of competent jurisdiction
530.30 changing the name of a person whose birth is registered in Minnesota and upon request of
530.31 such person if 18 years of age or older or having the status of emancipated minor, the state
530.32 registrar shall amend the birth record to show the new name. If the person is a minor or
530.33 an incapacitated person then a parent, guardian, or legal representative of the minor or
530.34 incapacitated person may make the request.

531.1 (d) When an applicant does not submit the minimum documentation required for
531.2 amending a vital record or when the state registrar has cause to question the validity
531.3 or completeness of the applicant's statements or the documentary evidence, and the
531.4 deficiencies are not corrected, the state registrar shall not amend the vital record. The
531.5 state registrar shall advise the applicant of the reason for this action and shall further
531.6 advise the applicant of the right of appeal to a court with competent jurisdiction over
531.7 the Department of Health.

531.8 Sec. 25. Minnesota Statutes 2012, section 144.225, subdivision 1, is amended to read:

531.9 Subdivision 1. **Public information; access to vital records.** Except as otherwise
531.10 provided for in this section and section 144.2252, information contained in vital records
531.11 shall be public information. Physical access to vital records shall be subject to the
531.12 supervision and regulation of ~~the state and local registrars~~ registrar and their employees
531.13 pursuant to rules promulgated by the commissioner in order to protect vital records from
531.14 loss, mutilation or destruction and to prevent improper disclosure of vital records which
531.15 are confidential or private data on individuals, as defined in section 13.02, subdivisions
531.16 3 and 12.

531.17 Sec. 26. Minnesota Statutes 2012, section 144.225, subdivision 4, is amended to read:

531.18 Subd. 4. **Access to records for research purposes.** The state registrar may permit
531.19 persons performing medical research access to the information restricted in subdivision
531.20 2 or 2a if those persons agree in writing not to disclose private or confidential data on
531.21 individuals.

531.22 Sec. 27. Minnesota Statutes 2012, section 144.225, subdivision 7, is amended to read:

531.23 Subd. 7. **Certified birth or death record.** (a) The state ~~or local~~ registrar or local
531.24 issuance office shall issue a certified birth or death record or a statement of no vital record
531.25 found to an individual upon the individual's proper completion of an attestation provided
531.26 by the commissioner and payment of the required fee:

531.27 (1) to a person who has a tangible interest in the requested vital record. A person
531.28 who has a tangible interest is:

531.29 (i) the subject of the vital record;

531.30 (ii) a child of the subject;

531.31 (iii) the spouse of the subject;

531.32 (iv) a parent of the subject;

531.33 (v) the grandparent or grandchild of the subject;

- 532.1 (vi) if the requested record is a death record, a sibling of the subject;
- 532.2 (vii) the party responsible for filing the vital record;
- 532.3 (viii) the legal custodian, guardian or conservator, or health care agent of the subject;
- 532.4 (ix) a personal representative, by sworn affidavit of the fact that the certified copy is
532.5 required for administration of the estate;
- 532.6 (x) a successor of the subject, as defined in section 524.1-201, if the subject is
532.7 deceased, by sworn affidavit of the fact that the certified copy is required for administration
532.8 of the estate;
- 532.9 (xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of
532.10 the fact that the certified copy is needed for the proper administration of the trust;
- 532.11 (xii) a person or entity who demonstrates that a certified vital record is necessary for
532.12 the determination or protection of a personal or property right, pursuant to rules adopted
532.13 by the commissioner; or
- 532.14 (xiii) adoption agencies in order to complete confidential postadoption searches as
532.15 required by section 259.83;
- 532.16 (2) to any local, state, or federal governmental agency upon request if the certified
532.17 vital record is necessary for the governmental agency to perform its authorized duties:
532.18 ~~An authorized governmental agency includes the Department of Human Services, the~~
532.19 ~~Department of Revenue, and the United States Citizenship and Immigration Services;~~
- 532.20 (3) to an attorney upon evidence of the attorney's license;
- 532.21 (4) pursuant to a court order issued by a court of competent jurisdiction. For
532.22 purposes of this section, a subpoena does not constitute a court order; or
- 532.23 (5) to a representative authorized by a person under clauses (1) to (4).
- 532.24 (b) ~~The state or local registrar~~ or local issuance office shall also issue a certified
532.25 death record to an individual described in paragraph (a), clause (1), items (ii) to (viii), if,
532.26 on behalf of the individual, a licensed mortician furnishes the registrar with a properly
532.27 completed attestation in the form provided by the commissioner within 180 days of the
532.28 time of death of the subject of the death record. This paragraph is not subject to the
532.29 requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

532.30 Sec. 28. Minnesota Statutes 2012, section 144.225, subdivision 8, is amended to read:

532.31 Subd. 8. **Standardized format for certified birth and death records.** ~~No later than~~
532.32 ~~July 1, 2000,~~ The commissioner shall ~~develop~~ maintain a standardized format for certified
532.33 birth records and death records issued by ~~the state and local registrars~~ registrar and local
532.34 issuance offices. The format shall incorporate security features in accordance with this
532.35 section. ~~The standardized format must be implemented on a statewide basis by July 1, 2001.~~

533.1 Sec. 29. Minnesota Statutes 2012, section 144.226, is amended to read:

533.2 **144.226 FEES.**

533.3 Subdivision 1. **Which services are for fee.** The fees for the following services shall
533.4 be the following or an amount prescribed by rule of the commissioner:

533.5 (a) The fee for the ~~issuance of~~ administrative review and processing of a request for
533.6 a certified vital record or a certification that the vital record cannot be found is \$9. ~~No~~
533.7 ~~fee shall be charged for a certified birth, stillbirth, or death record that is reissued within~~
533.8 ~~one year of the original issue, if an amendment is made to the vital record and if the~~
533.9 ~~previously issued vital record is surrendered.~~ The fee is payable at the time of application
533.10 and is nonrefundable.

533.11 (b) The fee for processing a request for the replacement of a birth record for
533.12 all events, except when filing a recognition of parentage pursuant to section 257.73,
533.13 subdivision 1, is \$40. The fee is payable at the time of application and is nonrefundable.

533.14 (c) The fee for administrative review and processing of a request for the filing of a
533.15 delayed registration of birth, stillbirth, or death is \$40. The fee is payable at the time of
533.16 application and is nonrefundable. ~~This fee includes one subsequent review of the request~~
533.17 ~~if the request is not acceptable upon the initial receipt.~~

533.18 (d) The fee for administrative review and processing of a request for the amendment
533.19 of any vital record ~~when requested more than 45 days after the filing of the vital record is~~
533.20 ~~\$40. No fee shall be charged for an amendment requested within 45 days after the filing~~
533.21 ~~of the vital record.~~ The fee is payable at the time of application and is nonrefundable.
533.22 ~~This fee includes one subsequent review of the request if the request is not acceptable~~
533.23 ~~upon the initial receipt.~~

533.24 (e) The fee for administrative review and processing of a request for the verification
533.25 of information from vital records is \$9 when the applicant furnishes the specific
533.26 information to locate the vital record. When the applicant does not furnish specific
533.27 information, the fee is \$20 per hour for staff time expended. Specific information includes
533.28 the correct date of the event and the correct name of the ~~registrant~~ subject of the record.
533.29 Fees charged shall approximate the costs incurred in searching and copying the vital
533.30 records. The fee is payable at the time of application and is nonrefundable.

533.31 (f) The fee for administrative review and processing of a request for the issuance
533.32 of a copy of any document on file pertaining to a vital record or statement that a related
533.33 document cannot be found is \$9. The fee is payable at the time of application and is
533.34 nonrefundable.

534.1 Subd. 2. **Fees to state government special revenue fund.** Fees collected under
534.2 this section by the state registrar shall be deposited in the state treasury and credited to
534.3 the state government special revenue fund.

534.4 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under
534.5 subdivision 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or
534.6 stillbirth record and for a certification that the vital record cannot be found. The ~~local~~
534.7 state registrar or local issuance office shall forward this amount to the commissioner of
534.8 management and budget for deposit into the account for the children's trust fund for the
534.9 prevention of child abuse established under section 256E.22. This surcharge shall not be
534.10 charged under those circumstances in which no fee for a certified birth or stillbirth record
534.11 is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of
534.12 management and budget that the assets in that fund exceed \$20,000,000, this surcharge
534.13 shall be discontinued.

534.14 (b) In addition to any fee prescribed under subdivision 1, there shall be a
534.15 nonrefundable surcharge of \$10 for each certified birth record. The ~~local~~
534.16 or local issuance office shall forward this amount to the commissioner of management and
534.17 budget for deposit in the general fund. ~~This surcharge shall not be charged under those~~
534.18 ~~circumstances in which no fee for a certified birth record is permitted under subdivision 1,~~
534.19 ~~paragraph (a).~~

534.20 Subd. 4. **Vital records surcharge.** (a) In addition to any fee prescribed under
534.21 subdivision 1, there is a nonrefundable surcharge of ~~\$2~~ \$4 for each certified and
534.22 noncertified birth, stillbirth, or death record, and for a certification that the record cannot
534.23 be found. The local issuance office or state registrar shall forward this amount to the
534.24 commissioner of management and budget to be deposited into the state government special
534.25 revenue fund. ~~This surcharge shall not be charged under those circumstances in which no~~
534.26 ~~fee for a birth, stillbirth, or death record is permitted under subdivision 1, paragraph (a).~~

534.27 (b) ~~Effective August 1, 2005, the surcharge in paragraph (a) is \$4.~~

534.28 Subd. 5. **Electronic verification.** A fee for the electronic verification or electronic
534.29 certification of a vital event, when the information being verified or certified is obtained
534.30 from a certified birth or death record, shall be established through contractual or
534.31 interagency agreements ~~with interested local, state, or federal government agencies.~~

534.32 Subd. 6. **Alternative payment methods.** Notwithstanding subdivision 1, alternative
534.33 payment methods may be approved and implemented by the state registrar or a local
534.34 registrar issuance office.

534.35 Sec. 30. [144.492] DEFINITIONS.

535.1 Subdivision 1. **Applicability.** For the purposes of sections 144.492 to 144.494, the
535.2 terms defined in this section have the meanings given them.

535.3 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

535.4 Subd. 3. **Joint commission.** "Joint commission" means the independent,
535.5 not-for-profit organization that accredits and certifies health care organizations and
535.6 programs in the United States.

535.7 Subd. 4. **Stroke.** "Stroke" means the sudden death of brain cells in a localized
535.8 area due to inadequate blood flow.

535.9 Sec. 31. **[144.493] CRITERIA.**

535.10 Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a
535.11 comprehensive stroke center if the hospital has been certified as a comprehensive stroke
535.12 center by the joint commission or another nationally recognized accreditation entity.

535.13 Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke
535.14 center if the hospital has been certified as a primary stroke center by the joint commission
535.15 or another nationally recognized accreditation entity.

535.16 Subd. 3. **Acute stroke ready hospital.** A hospital meets the criteria for an acute
535.17 stroke ready hospital if the hospital has the following elements of an acute stroke ready
535.18 hospital:

535.19 (1) an acute stroke team available or on-call 24 hours a days, seven days a week;

535.20 (2) written stroke protocols, including triage, stabilization of vital functions, initial
535.21 diagnostic tests, and use of medications;

535.22 (3) a written plan and letter of cooperation with emergency medical services regarding
535.23 triage and communication that are consistent with regional patient care procedures;

535.24 (4) emergency department personnel who are trained in diagnosing and treating
535.25 acute stroke;

535.26 (5) the capacity to complete basic laboratory tests, electrocardiograms, and chest
535.27 x-rays 24 hours a day, seven days a week;

535.28 (6) the capacity to perform and interpret brain injury imaging studies 24 hours a
535.29 day, seven days a week;

535.30 (7) written protocols that detail available emergent therapies and reflect current
535.31 treatment guidelines, which include performance measures and are revised at least annually;

535.32 (8) a neurosurgery coverage plan, call schedule, and a triage and transportation plan;

535.33 (9) transfer protocols and agreements for stroke patients; and

535.34 (10) a designated medical director with experience and expertise in acute stroke care.

536.1 Sec. 32. **[144.494] DESIGNATING STROKE CENTERS AND STROKE**
 536.2 **HOSPITALS.**

536.3 Subdivision 1. Naming privileges. Unless it has been designated as a stroke center
 536.4 or stroke hospital pursuant to section 144.493, no hospital shall use the term "stroke
 536.5 center" or "stroke hospital" in its name or its advertising or shall otherwise indicate it
 536.6 has stroke treatment capabilities.

536.7 Subd. 2. Designation. A hospital that voluntarily meets the criteria for a
 536.8 comprehensive stroke center, primary stroke center, or acute stroke ready hospital may
 536.9 apply to the commissioner for designation, and upon the commissioner's review and
 536.10 approval of the application, shall be designated as a comprehensive stroke center, a
 536.11 primary stroke center, or an acute stroke ready hospital for a three-year period. If a hospital
 536.12 loses its certification as a comprehensive stroke center or primary stroke center from
 536.13 the joint commission or other nationally recognized accreditation entity, its Minnesota
 536.14 designation shall be immediately withdrawn. Prior to the expiration of the three-year
 536.15 designation, a hospital seeking to remain part of the voluntary acute stroke system may
 536.16 reapply to the commissioner for designation.

536.17 Sec. 33. **[144.554] HEALTH FACILITIES CONSTRUCTION PLAN**
 536.18 **SUBMITTAL AND FEES.**

536.19 For hospitals, nursing homes, boarding care homes, residential hospices, supervised
 536.20 living facilities, freestanding outpatient surgical centers, and end-stage renal disease
 536.21 facilities, the commissioner shall collect a fee for the review and approval of architectural,
 536.22 mechanical, and electrical plans and specifications submitted before construction begins
 536.23 for each project relative to construction of new buildings, additions to existing buildings,
 536.24 or remodeling or alterations of existing buildings. All fees collected in this section shall
 536.25 be deposited in the state treasury and credited to the state government special revenue
 536.26 fund. Fees must be paid at the time of submission of final plans for review and are not
 536.27 refundable. The fee is calculated as follows:

<u>Construction project total estimated cost</u>	<u>Fee</u>
<u>\$0 - \$10,000</u>	<u>\$30</u>
<u>\$10,001 - \$50,000</u>	<u>\$150</u>
<u>\$50,001 - \$100,000</u>	<u>\$300</u>
<u>\$100,001 - \$150,000</u>	<u>\$450</u>
<u>\$150,001 - \$200,000</u>	<u>\$600</u>
<u>\$200,001 - \$250,000</u>	<u>\$750</u>
<u>\$250,001 - \$300,000</u>	<u>\$900</u>
<u>\$300,001 - \$350,000</u>	<u>\$1,050</u>

537.1	<u>\$350,001 - \$400,000</u>	\$1,200
537.2	<u>\$400,001 - \$450,000</u>	\$1,350
537.3	<u>\$450,001 - \$500,000</u>	\$1,500
537.4	<u>\$500,001 - \$550,000</u>	\$1,650
537.5	<u>\$550,001 - \$600,000</u>	\$1,800
537.6	<u>\$600,001 - \$650,000</u>	\$1,950
537.7	<u>\$650,001 - \$700,000</u>	\$2,100
537.8	<u>\$700,001 - \$750,000</u>	\$2,250
537.9	<u>\$750,001 - \$800,000</u>	\$2,400
537.10	<u>\$800,001 - \$850,000</u>	\$2,550
537.11	<u>\$850,001 - \$900,000</u>	\$2,700
537.12	<u>\$900,001 - \$950,000</u>	\$2,850
537.13	<u>\$950,001 - \$1,000,000</u>	\$3,000
537.14	<u>\$1,000,001 - \$1,050,000</u>	\$3,150
537.15	<u>\$1,050,001 - \$1,100,000</u>	\$3,300
537.16	<u>\$1,100,001 - \$1,150,000</u>	\$3,450
537.17	<u>\$1,150,001 - \$1,200,000</u>	\$3,600
537.18	<u>\$1,200,001 - \$1,250,000</u>	\$3,750
537.19	<u>\$1,250,001 - \$1,300,000</u>	\$3,900
537.20	<u>\$1,300,001 - \$1,350,000</u>	\$4,050
537.21	<u>\$1,350,001 - \$1,400,000</u>	\$4,200
537.22	<u>\$1,400,001 - \$1,450,000</u>	\$4,350
537.23	<u>\$1,450,001 - \$1,500,000</u>	\$4,500
537.24	<u>\$1,500,001 and over</u>	\$4,800

537.25 Sec. 34. Minnesota Statutes 2012, section 144.966, subdivision 2, is amended to read:

537.26 Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The
 537.27 commissioner of health shall establish a Newborn Hearing Screening Advisory Committee
 537.28 to advise and assist the Department of Health and the Department of Education in:

537.29 (1) developing protocols and timelines for screening, rescreening, and diagnostic
 537.30 audiological assessment and early medical, audiological, and educational intervention
 537.31 services for children who are deaf or hard-of-hearing;

537.32 (2) designing protocols for tracking children from birth through age three that may
 537.33 have passed newborn screening but are at risk for delayed or late onset of permanent
 537.34 hearing loss;

537.35 (3) designing a technical assistance program to support facilities implementing the
 537.36 screening program and facilities conducting rescreening and diagnostic audiological
 537.37 assessment;

537.38 (4) designing implementation and evaluation of a system of follow-up and tracking;
 537.39 and

538.1 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
538.2 culturally appropriate services for children with a confirmed hearing loss and their families.

538.3 (b) The commissioner of health shall appoint at least one member from each of the
538.4 following groups with no less than two of the members being deaf or hard-of-hearing:

538.5 (1) a representative from a consumer organization representing culturally deaf
538.6 persons;

538.7 (2) a parent with a child with hearing loss representing a parent organization;

538.8 (3) a consumer from an organization representing oral communication options;

538.9 (4) a consumer from an organization representing cued speech communication
538.10 options;

538.11 (5) an audiologist who has experience in evaluation and intervention of infants
538.12 and young children;

538.13 (6) a speech-language pathologist who has experience in evaluation and intervention
538.14 of infants and young children;

538.15 (7) two primary care providers who have experience in the care of infants and young
538.16 children, one of which shall be a pediatrician;

538.17 (8) a representative from the early hearing detection intervention teams;

538.18 (9) a representative from the Department of Education resource center for the deaf
538.19 and hard-of-hearing or the representative's designee;

538.20 (10) a representative of the Commission of Deaf, DeafBlind and Hard-of-Hearing
538.21 Minnesotans;

538.22 (11) a representative from the Department of Human Services Deaf and
538.23 Hard-of-Hearing Services Division;

538.24 (12) one or more of the Part C coordinators from the Department of Education, the
538.25 Department of Health, or the Department of Human Services or the department's designees;

538.26 (13) the Department of Health early hearing detection and intervention coordinators;

538.27 (14) two birth hospital representatives from one rural and one urban hospital;

538.28 (15) a pediatric geneticist;

538.29 (16) an otolaryngologist;

538.30 (17) a representative from the Newborn Screening Advisory Committee under
538.31 this subdivision; and

538.32 (18) a representative of the Department of Education regional low-incidence
538.33 facilitators.

538.34 The commissioner must complete the appointments required under this subdivision by
538.35 September 1, 2007.

539.1 (c) The Department of Health member shall chair the first meeting of the committee.
539.2 At the first meeting, the committee shall elect a chair from its membership. The committee
539.3 shall meet at the call of the chair, at least four times a year. The committee shall adopt
539.4 written bylaws to govern its activities. The Department of Health shall provide technical
539.5 and administrative support services as required by the committee. These services shall
539.6 include technical support from individuals qualified to administer infant hearing screening,
539.7 rescreening, and diagnostic audiological assessments.

539.8 Members of the committee shall receive no compensation for their service, but
539.9 shall be reimbursed as provided in section 15.059 for expenses incurred as a result of
539.10 their duties as members of the committee.

539.11 (d) This subdivision expires June 30, ~~2013~~ 2019.

539.12 Sec. 35. Minnesota Statutes 2012, section 144.966, subdivision 3a, is amended to read:

539.13 Subd. 3a. **Support services to families.** (a) The commissioner shall contract with a
539.14 nonprofit organization to provide support and assistance to families with children who are
539.15 deaf or have a hearing loss. The family support provided must include:

539.16 (1) direct hearing loss specific parent-to-parent assistance and unbiased information
539.17 on communication, educational, and medical options; and

539.18 (2) individualized deaf or hard-of-hearing mentors who provide education, including
539.19 instruction in American Sign Language as an available option.

539.20 The commissioner shall give preference to a nonprofit organization that has the ability to
539.21 provide these services throughout the state.

539.22 (b) Family participation in the support and assistance services is voluntary.

539.23 Sec. 36. Minnesota Statutes 2012, section 144.98, subdivision 3, is amended to read:

539.24 Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must
539.25 be accompanied by the annual fees specified in this subdivision. The annual fees include:

539.26 (1) base accreditation fee, ~~\$1,500~~ \$600;

539.27 (2) sample preparation techniques fee, \$200 per technique;

539.28 (3) an administrative fee for laboratories located outside this state, ~~\$3,750~~ \$2,000; and

539.29 (4) test category fees.

539.30 (b) For the programs in subdivision 3a, the commissioner may accredit laboratories
539.31 for fields of testing under the categories listed in clauses (1) to (10) upon completion of
539.32 the application requirements provided by subdivision 6 and receipt of the fees for each
539.33 category under each program that accreditation is requested. The categories offered and
539.34 related fees include:

- 540.1 (1) microbiology, ~~\$450~~ \$200;
- 540.2 (2) inorganics, ~~\$450~~ \$200;
- 540.3 (3) metals, ~~\$1,000~~ \$500;
- 540.4 (4) volatile organics, ~~\$1,300~~ \$1,000;
- 540.5 (5) other organics, ~~\$1,300~~ \$1,000;
- 540.6 (6) radiochemistry, ~~\$1,500~~ \$750;
- 540.7 (7) emerging contaminants, ~~\$1,500~~ \$1,000;
- 540.8 (8) agricultural contaminants, ~~\$1,250~~ \$1,000;
- 540.9 (9) toxicity (bioassay), ~~\$1,000~~ \$500; and
- 540.10 (10) physical characterization, \$250.

540.11 (c) The total annual fee includes the base fee, the sample preparation techniques
540.12 fees, the test category fees per program, and, when applicable, an administrative fee for
540.13 out-of-state laboratories.

540.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

540.15 Sec. 37. Minnesota Statutes 2012, section 144.98, subdivision 5, is amended to read:

540.16 Subd. 5. **State government special revenue fund.** Fees collected by the
540.17 commissioner under this section must be deposited in the state treasury and credited to
540.18 the state government special revenue fund.

540.19 **EFFECTIVE DATE.** This section is effective the day following final enactment.

540.20 Sec. 38. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
540.21 to read:

540.22 Subd. 10. **Establishing a selection committee.** (a) The commissioner shall
540.23 establish a selection committee for the purpose of recommending approval of qualified
540.24 laboratory assessors and assessment bodies. Committee members shall demonstrate
540.25 competence in assessment practices. The committee shall initially consist of seven
540.26 members appointed by the commissioner as follows:

540.27 (1) one member from a municipal laboratory accredited by the commissioner;

540.28 (2) one member from an industrial treatment laboratory accredited by the
540.29 commissioner;

540.30 (3) one member from a commercial laboratory located in this state and accredited by
540.31 the commissioner;

540.32 (4) one member from a commercial laboratory located outside the state and
540.33 accredited by the commissioner;

541.1 (5) one member from a nongovernmental client of environmental laboratories;

541.2 (6) one member from a professional organization with a demonstrated interest in
541.3 environmental laboratory data and accreditation; and

541.4 (7) one employee of the laboratory accreditation program administered by the
541.5 department.

541.6 (b) Committee appointments begin on January 1 and end on December 31 of the
541.7 same year.

541.8 (c) The commissioner shall appoint persons to fill vacant committee positions,
541.9 expand the total number of appointed positions, or change the designated positions upon
541.10 the advice of the committee.

541.11 (d) The commissioner shall rescind the appointment of a selection committee
541.12 member for sufficient cause as the commissioner determines, such as:

541.13 (1) neglect of duty;

541.14 (2) failure to notify the commissioner of a real or perceived conflict of interest;

541.15 (3) nonconformance with committee procedures;

541.16 (4) failure to demonstrate competence in assessment practices; or

541.17 (5) official misconduct.

541.18 (e) Members of the selection committee shall be compensated according to the
541.19 provisions in section 15.059, subdivision 3.

541.20 Sec. 39. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
541.21 to read:

541.22 Subd. 11. **Activities of the selection committee.** (a) The selection committee shall
541.23 determine assessor and assessment organization application requirements, the frequency
541.24 of application submittal, and the application review schedule. The commissioner shall
541.25 publish the application requirements and procedures on the accreditation program Web site.

541.26 (b) In its selection process, the committee shall ensure its application requirements
541.27 and review process:

541.28 (1) meet the standards implemented in subdivision 2a;

541.29 (2) ensure assessors have demonstrated competence in technical disciplines offered
541.30 for accreditation by the commissioner; and

541.31 (3) consider any history of repeated nonconformance or complaints regarding
541.32 assessors or assessment bodies.

541.33 (c) The selection committee shall consider an application received from qualified
541.34 applicants and shall supply a list of recommended assessors and assessment bodies to

542.1 the commissioner of health no later than 90 days after the commissioner notifies the
542.2 committee of the need for review of applications.

542.3 Sec. 40. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
542.4 to read:

542.5 **Subd. 12. Commissioner approval of assessors and scheduling of assessments.**

542.6 (a) The commissioner shall approve assessors who:

542.7 (1) are employed by the commissioner for the purpose of accrediting laboratories
542.8 and demonstrate competence in assessment practices for environmental laboratories; or

542.9 (2) are employed by a state or federal agency with established agreements for
542.10 mutual assistance or recognition with the commissioner and demonstrate competence in
542.11 assessment practices for environmental laboratories.

542.12 (b) The commissioner may approve other assessors or assessment organizations who
542.13 are recommended by the selection committee according to subdivision 11, paragraph

542.14 (c). The commissioner shall publish the list of assessors and assessment organizations
542.15 approved from the recommendations.

542.16 (c) The commissioner shall rescind approval for an assessor or assessment
542.17 organization for sufficient cause as the commissioner determines, such as:

542.18 (1) failure to meet the minimum qualifications for performing assessments;

542.19 (2) lack of availability;

542.20 (3) nonconformance with the applicable laws, rules, standards, policies, and
542.21 procedures;

542.22 (4) misrepresentation of application information regarding qualifications and
542.23 training; or

542.24 (5) excessive cost to perform the assessment activities.

542.25 Sec. 41. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
542.26 to read:

542.27 **Subd. 13. Laboratory requirements for assessor selection and scheduling**

542.28 **assessments.** (a) A laboratory accredited or seeking accreditation that requires an

542.29 assessment by the commissioner must select an assessor, group of assessors, or assessment
542.30 organization from the published list specified in subdivision 12, paragraph (b). An

542.31 accredited laboratory must complete an assessment and make all corrective actions at least
542.32 once every 24 months. Unless the commissioner grants interim accreditation, a laboratory

542.33 seeking accreditation must complete an assessment and make all corrective actions

543.1 prior to, but no earlier than, 18 months prior to the date the application is submitted to
543.2 the commissioner.

543.3 (b) A laboratory shall not select the same assessor more than twice in succession
543.4 for assessments of the same facility unless the laboratory receives written approval
543.5 from the commissioner for the selection. The laboratory must supply a written request
543.6 to the commissioner for approval and must justify the reason for the request and provide
543.7 the alternate options considered.

543.8 (c) A laboratory must select assessors appropriate to the size and scope of the
543.9 laboratory's application or existing accreditation.

543.10 (d) A laboratory must enter into its own contract for direct payment of the assessors
543.11 or assessment organization. The contract must authorize the assessor, assessment
543.12 organization, or subcontractors to release all records to the commissioner regarding the
543.13 assessment activity, when the assessment is performed in compliance with this section.

543.14 (e) A laboratory must agree to permit other assessors as selected by the commissioner
543.15 to participate in the assessment activities.

543.16 (f) If the laboratory determines no approved assessor is available to perform
543.17 the assessment, the laboratory must notify the commissioner in writing and provide a
543.18 justification for the determination. If the commissioner confirms no approved assessor
543.19 is available, the commissioner may designate an alternate assessor from those approved
543.20 in subdivision 12, paragraph (a), or the commissioner may delay the assessment until
543.21 an assessor is available. If an approved alternate assessor performs the assessment, the
543.22 commissioner may collect fees equivalent to the cost of performing the assessment
543.23 activities.

543.24 (g) Fees collected under this section are deposited in a special account and are
543.25 annually appropriated to the commissioner for the purpose of performing assessment
543.26 activities.

543.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

543.28 Sec. 42. Minnesota Statutes 2012, section 144.99, subdivision 4, is amended to read:

543.29 Subd. 4. **Administrative penalty orders.** (a) The commissioner may issue an
543.30 order requiring violations to be corrected and administratively assessing monetary
543.31 penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The
543.32 procedures in section 144.991 must be followed when issuing administrative penalty
543.33 orders. Except in the case of repeated or serious violations, the penalty assessed in the
543.34 order must be forgiven if the person who is subject to the order demonstrates in writing
543.35 to the commissioner before the 31st day after receiving the order that the person has

544.1 corrected the violation or has developed a corrective plan acceptable to the commissioner.
544.2 The maximum amount of an administrative penalty order is \$10,000 for each violator for
544.3 all violations by that violator identified in an inspection or review of compliance.

544.4 (b) Notwithstanding paragraph (a), the commissioner may issue to a large public
544.5 water supply, serving a population of more than 10,000 persons, an administrative penalty
544.6 order imposing a penalty of at least \$1,000 per day per violation, not to exceed \$10,000
544.7 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

544.8 (c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead
544.9 firm or person performing regulated lead work, an administrative penalty order imposing a
544.10 penalty of at least \$5,000 per violation per day, not to exceed \$10,000 for each violation of
544.11 sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from
544.12 monetary penalties in this section shall be deposited in the state treasury and credited to
544.13 the state government special revenue fund.

544.14 Sec. 43. **[145.4716] SAFE HARBOR FOR SEXUALLY EXPLOITED YOUTH.**

544.15 Subdivision 1. **Director.** The commissioner of health shall establish a position for a
544.16 director of child sex trafficking prevention.

544.17 Subd. 2. **Duties of director.** The director of child sex trafficking prevention is
544.18 responsible for the following:

544.19 (1) developing and providing comprehensive training on sexual exploitation of
544.20 youth for social service professionals, medical professionals, public health workers, and
544.21 criminal justice professionals;

544.22 (2) collecting, organizing, maintaining, and disseminating information on sexual
544.23 exploitation and services across the state, including maintaining a list of resources on the
544.24 Department of Health Web site;

544.25 (3) monitoring and applying for federal funding for antitrafficking efforts that may
544.26 benefit victims in the state;

544.27 (4) managing grant programs established under this act;

544.28 (5) identifying best practices in serving sexually exploited youth, as defined in
544.29 section 260C.007, subdivision 31;

544.30 (6) providing oversight of and technical support to regional navigators pursuant to
544.31 section 145.4717;

544.32 (7) conducting a comprehensive evaluation of the statewide program for safe harbor
544.33 of sexually exploited youth; and

545.1 (8) developing a policy, consistent with the requirements of chapter 13, for sharing
545.2 data related to sexually exploited youth, as defined in section 260C.007, subdivision 31,
545.3 among regional navigators and community-based advocates.

545.4 Sec. 44. **[145.4717] REGIONAL NAVIGATOR GRANTS.**

545.5 The commissioner of health, through its director of child sex trafficking prevention,
545.6 established in section 145.4716, shall provide grants to regional navigators serving six
545.7 regions of the state to be determined by the commissioner. Each regional navigator must
545.8 develop and annually submit a work plan to the director of child sex trafficking prevention.
545.9 The work plans must include, but are not limited to, the following information:

545.10 (1) a needs statement specific to the region, including an examination of the
545.11 population at risk;

545.12 (2) regional resources available to sexually exploited youth, as defined in section
545.13 260C.007, subdivision 31;

545.14 (3) grant goals and measurable outcomes; and

545.15 (4) grant activities including timelines.

545.16 Sec. 45. **[145.4718] PROGRAM EVALUATION.**

545.17 (a) The director of child sex trafficking prevention, established under section
545.18 145.4716, must conduct, or contract for, comprehensive evaluation of the statewide
545.19 program for safe harbor for sexually exploited youth. The first evaluation must be
545.20 completed by June 30, 2015, and must be submitted to the commissioner of health by
545.21 September 1, 2015, and every two years thereafter. The evaluation must consider whether
545.22 the program is reaching intended victims and whether support services are available,
545.23 accessible, and adequate for sexually exploited youth, as defined in section 260C.007,
545.24 subdivision 31.

545.25 (b) In conducting the evaluation, the director of child sex trafficking prevention must
545.26 consider evaluation of outcomes, including whether the program increases identification
545.27 of sexually exploited youth, coordination of investigations, access to services and housing
545.28 available for sexually exploited youth, and improved effectiveness of services. The
545.29 evaluation must also include examination of the ways in which penalties under section
545.30 609.3241 are assessed, collected, and distributed to ensure funding for investigation,
545.31 prosecution, and victim services to combat sexual exploitation of youth.

545.32 Sec. 46. Minnesota Statutes 2012, section 145.906, is amended to read:

545.33 **145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.**

546.1 (a) The commissioner of health shall work with health care facilities, licensed health
546.2 and mental health care professionals, the women, infants, and children (WIC) program,
546.3 mental health advocates, consumers, and families in the state to develop materials and
546.4 information about postpartum depression, including treatment resources, and develop
546.5 policies and procedures to comply with this section.

546.6 (b) Physicians, traditional midwives, and other licensed health care professionals
546.7 providing prenatal care to women must have available to women and their families
546.8 information about postpartum depression.

546.9 (c) Hospitals and other health care facilities in the state must provide departing new
546.10 mothers and fathers and other family members, as appropriate, with written information
546.11 about postpartum depression, including its symptoms, methods of coping with the illness,
546.12 and treatment resources.

546.13 (d) Information about postpartum depression, including its symptoms, potential
546.14 impact on families, and treatment resources, must be available at WIC sites.

546.15 (e) The commissioner of health, in collaboration with the commissioner of human
546.16 services and to the extent authorized by the federal Centers for Disease Control and
546.17 Prevention, shall review the materials and information related to postpartum depression to
546.18 determine their effectiveness in transmitting the information in a way that reduces racial
546.19 health disparities as reported in surveys of maternal attitudes and experiences before,
546.20 during, and after pregnancy, including those conducted by the commissioner of health. The
546.21 commissioner shall implement changes to reduce racial health disparities in the information
546.22 reviewed, as needed, and ensure that women of color are receiving the information.

546.23 Sec. 47. **[145.907] MATERNAL DEPRESSION; DEFINITION.**

546.24 "Maternal depression" means depression or other perinatal mood or anxiety disorder
546.25 experienced by a woman during pregnancy or during the first year following the birth of
546.26 her child.

546.27 Sec. 48. Minnesota Statutes 2012, section 145.986, is amended to read:

546.28 **145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

546.29 Subdivision 1. **Grants to local communities Purpose.** The purpose of the statewide
546.30 health improvement program is to:

546.31 (1) address the top three leading preventable causes of illness and death: tobacco use
546.32 and exposure, poor diet, and lack of regular physical activity;

546.33 (2) promote the development, availability, and use of evidence-based, community
546.34 level, comprehensive strategies to create healthy communities; and

547.1 (3) measure the impact of the evidence-based, community health improvement
547.2 practices which over time work to contain health care costs and reduce chronic diseases.

547.3 Subd. 1a. Grants to local communities. (a) Beginning July 1, 2009, the
547.4 commissioner of health shall award competitive grants to community health boards
547.5 established pursuant to section 145A.09 and tribal governments to convene, coordinate,
547.6 and implement evidence-based strategies targeted at reducing the percentage of
547.7 Minnesotans who are obese or overweight and to reduce the use of tobacco. Grants shall
547.8 be awarded to all community health boards and tribal governments whose proposals
547.9 demonstrate the ability to implement programs designed to achieve the purposes in
547.10 subdivision 1 and other requirements of this section.

547.11 (b) Grantee activities shall:

547.12 (1) be based on scientific evidence;

547.13 (2) be based on community input;

547.14 (3) address behavior change at the individual, community, and systems levels;

547.15 (4) occur in community, school, worksite, and health care settings; and

547.16 (5) be focused on policy, systems, and environmental changes that support healthy
547.17 behaviors; and

547.18 (6) address the health disparities and inequities that exist in the grantee's community.

547.19 (c) To receive a grant under this section, community health boards and tribal
547.20 governments must submit proposals to the commissioner. A local match of ten percent
547.21 of the total funding allocation is required. This local match may include funds donated
547.22 by community partners.

547.23 (d) In order to receive a grant, community health boards and tribal governments
547.24 must submit a health improvement plan to the commissioner of health for approval. The
547.25 commissioner may require the plan to identify a community leadership team, community
547.26 partners, and a community action plan that includes an assessment of area strengths and
547.27 needs, proposed action strategies, technical assistance needs, and a staffing plan.

547.28 (e) The grant recipient must implement the health improvement plan, evaluate the
547.29 effectiveness of the interventions strategies, and modify or discontinue interventions
547.30 strategies found to be ineffective.

547.31 ~~(f) By January 15, 2011, the commissioner of health shall recommend whether any~~
547.32 ~~funding should be distributed to community health boards and tribal governments based~~
547.33 ~~on health disparities demonstrated in the populations served.~~

547.34 (g) (f) Grant recipients shall report their activities and their progress toward the
547.35 outcomes established under subdivision 2 to the commissioner in a format and at a time
547.36 specified by the commissioner.

548.1 ~~(h)~~ (g) All grant recipients shall be held accountable for making progress toward
548.2 the measurable outcomes established in subdivision 2. The commissioner shall require a
548.3 corrective action plan and may reduce the funding level of grant recipients that do not
548.4 make adequate progress toward the measurable outcomes.

548.5 Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet
548.6 the goals specified in subdivision 1, and annually review the progress of grant recipients
548.7 in meeting the outcomes.

548.8 (b) The commissioner shall measure current public health status, using existing
548.9 measures and data collection systems when available, to determine baseline data against
548.10 which progress shall be monitored.

548.11 Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide
548.12 content expertise, technical expertise, ~~and~~ training to grant recipients and advice on
548.13 evidence-based strategies, including those based on populations and types of communities
548.14 served. The commissioner shall ensure that the statewide health improvement program
548.15 meets the outcomes established under subdivision 2 by conducting a comprehensive
548.16 statewide evaluation and assisting grant recipients to modify or discontinue interventions
548.17 found to be ineffective.

548.18 (b) For the purposes of carrying out the grant program under this section, including
548.19 for administrative purposes, the commissioner shall award contracts to appropriate entities
548.20 to assist in training and provide technical assistance to grantees.

548.21 (c) Contracts awarded under paragraph (b) may be used to provide technical
548.22 assistance and training in the areas of:

548.23 (1) community engagement and capacity building;

548.24 (2) tribal support;

548.25 (3) community asset building and risk behavior reduction;

548.26 (4) legal;

548.27 (5) communications;

548.28 (6) community, school, health care, work site, and other site-specific strategies; and

548.29 (7) health equity.

548.30 Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3,
548.31 the commissioner shall conduct a biennial evaluation of the statewide health improvement
548.32 program funded under this section. Grant recipients shall cooperate with the commissioner
548.33 in the evaluation and provide the commissioner with the information necessary to conduct
548.34 the evaluation.

549.1 (b) Grant recipients will collect, monitor, and submit to the Department of Health
549.2 baseline and annual data and provide information to improve the quality and impact of
549.3 community health improvement strategies.

549.4 (c) For the purposes of carrying out the grant program under this section, including
549.5 for administrative purposes, the commissioner shall award contracts to appropriate entities
549.6 to assist in designing and implementing evaluation systems.

549.7 (d) Contracts awarded under paragraph (c) may be used to:

549.8 (1) develop grantee monitoring and reporting systems to track grantee progress,
549.9 including aggregated and disaggregated data;

549.10 (2) manage, analyze, and report program evaluation data results; and

549.11 (3) utilize innovative support tools to analyze and predict the impact of prevention
549.12 strategies on health outcomes and state health care costs over time.

549.13 **Subd. 5. Report.** The commissioner shall submit a biennial report to the legislature
549.14 on the statewide health improvement program funded under this section. ~~These reports~~
549.15 The report must include information on each grant recipients recipient, including the
549.16 activities that were conducted by the grantee using grant funds, evaluation data, and
549.17 outcome measures, if available. the grantee's progress toward achieving the measurable
549.18 outcomes established under subdivision 2, and the data provided to the commissioner by
549.19 the grantee to measure these outcomes for grant activities. The commissioner shall provide
549.20 information on grants in which a corrective action plan was required under subdivision
549.21 1a, the types of plan action, and the progress that has been made toward meeting the
549.22 measurable outcomes. In addition, the commissioner shall provide recommendations
549.23 on future areas of focus for health improvement. These reports are due by January 15
549.24 of every other year, beginning in 2010. ~~In the report due on January 15, 2010, the~~
549.25 ~~commissioner shall include recommendations on a sustainable funding source for the~~
549.26 ~~statewide health improvement program other than the health care access fund~~ In the report
549.27 due on January 15, 2014, the commissioner shall include a description of the contracts
549.28 awarded under subdivision 4, paragraph (c), and the monitoring and evaluation systems
549.29 that were designed and implemented under these contracts.

549.30 **Subd. 6. Supplantation of existing funds.** Community health boards and tribal
549.31 governments must use funds received under this section to develop new programs, expand
549.32 current programs that work to reduce the percentage of Minnesotans who are obese or
549.33 overweight or who use tobacco, or replace discontinued state or federal funds previously
549.34 used to reduce the percentage of Minnesotans who are obese or overweight or who use
549.35 tobacco. Funds must not be used to supplant current state or local funding to community

550.1 health boards or tribal governments used to reduce the percentage of Minnesotans who are
550.2 obese or overweight or to reduce tobacco use.

550.3 Sec. 49. Minnesota Statutes 2012, section 145A.17, subdivision 1, is amended to read:

550.4 Subdivision 1. **Establishment; goals.** The commissioner shall establish a program
550.5 to fund family home visiting programs designed to foster healthy beginnings, improve
550.6 pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce
550.7 juvenile delinquency, promote positive parenting and resiliency in children, and promote
550.8 family health and economic self-sufficiency for children and families. The commissioner
550.9 shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of
550.10 professionals and paraprofessionals from the fields of public health nursing, social work,
550.11 and early childhood education. A program funded under this section must serve families
550.12 at or below 200 percent of the federal poverty guidelines, and other families determined
550.13 to be at risk, including but not limited to being at risk for child abuse, child neglect, or
550.14 juvenile delinquency. Programs must begin prenatally whenever possible and must be
550.15 targeted to families with:

- 550.16 (1) adolescent parents;
- 550.17 (2) a history of alcohol or other drug abuse;
- 550.18 (3) a history of child abuse, domestic abuse, or other types of violence;
- 550.19 (4) a history of domestic abuse, rape, or other forms of victimization;
- 550.20 (5) reduced cognitive functioning;
- 550.21 (6) a lack of knowledge of child growth and development stages;
- 550.22 (7) low resiliency to adversities and environmental stresses;
- 550.23 (8) insufficient financial resources to meet family needs;
- 550.24 (9) a history of homelessness;
- 550.25 (10) a risk of long-term welfare dependence or family instability due to employment
550.26 barriers; ~~or~~
- 550.27 (11) a serious mental health disorder, including maternal depression as defined in
550.28 section 145.907; or
- 550.29 ~~(11)~~ (12) other risk factors as determined by the commissioner.

550.30 Sec. 50. Minnesota Statutes 2012, section 149A.02, subdivision 1a, is amended to read:

550.31 Subd. 1a. **Alkaline hydrolysis.** "Alkaline hydrolysis" means the reduction of a dead
550.32 human body to essential elements through ~~exposure to a combination of heat and alkaline~~
550.33 ~~hydrolysis and the repositioning or movement of the body during the process to facilitate~~
550.34 ~~reduction~~, a water-based dissolution process using alkaline chemicals, heat, agitation, and

551.1 pressure to accelerate natural decomposition; the processing of the hydrolyzed remains
551.2 after removal from the alkaline hydrolysis chamber, vessel; placement of the processed
551.3 remains in a hydrolyzed remains container; and release of the hydrolyzed remains to an
551.4 appropriate party. Alkaline hydrolysis is a form of final disposition.

551.5 Sec. 51. Minnesota Statutes 2012, section 149A.02, is amended by adding a
551.6 subdivision to read:

551.7 Subd. 1b. **Alkaline hydrolysis container.** "Alkaline hydrolysis container" means a
551.8 hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily
551.9 fluids that encases the body and into which a dead human body is placed prior to insertion
551.10 into an alkaline hydrolysis vessel. Alkaline hydrolysis containers may be hydrolyzable or
551.11 biodegradable alternative containers or caskets.

551.12 Sec. 52. Minnesota Statutes 2012, section 149A.02, is amended by adding a
551.13 subdivision to read:

551.14 Subd. 1c. **Alkaline hydrolysis facility.** "Alkaline hydrolysis facility" means a
551.15 building or structure containing one or more alkaline hydrolysis vessels for the alkaline
551.16 hydrolysis of dead human bodies.

551.17 Sec. 53. Minnesota Statutes 2012, section 149A.02, is amended by adding a
551.18 subdivision to read:

551.19 Subd. 1d. **Alkaline hydrolysis vessel.** "Alkaline hydrolysis vessel" means the
551.20 container in which the alkaline hydrolysis of a dead human body is performed.

551.21 Sec. 54. Minnesota Statutes 2012, section 149A.02, subdivision 2, is amended to read:

551.22 Subd. 2. **Alternative container.** "Alternative container" means a nonmetal
551.23 receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed
551.24 for the encasement of dead human bodies and is made of hydrolyzable or biodegradable
551.25 materials, corrugated cardboard, fiberboard, pressed-wood, or other like materials.

551.26 Sec. 55. Minnesota Statutes 2012, section 149A.02, subdivision 3, is amended to read:

551.27 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means
551.28 any action normally taken by a funeral provider in anticipation of or preparation for the
551.29 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

551.30 Sec. 56. Minnesota Statutes 2012, section 149A.02, subdivision 4, is amended to read:

552.1 Subd. 4. **Cash advance item.** "Cash advance item" means any item of service
552.2 or merchandise described to a purchaser as a "cash advance," "accommodation," "cash
552.3 disbursement," or similar term. A cash advance item is also any item obtained from a
552.4 third party and paid for by the funeral provider on the purchaser's behalf. Cash advance
552.5 items include, but are not limited to, cemetery, alkaline hydrolysis, or crematory services,
552.6 pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, obituary
552.7 notices, gratuities, and death records.

552.8 Sec. 57. Minnesota Statutes 2012, section 149A.02, subdivision 5, is amended to read:

552.9 Subd. 5. **Casket.** "Casket" means a rigid container which is designed for the
552.10 encasement of a dead human body and is usually constructed of hydrolyzable or
552.11 biodegradable materials, wood, metal, fiberglass, plastic, or like material, and ornamented
552.12 and lined with fabric.

552.13 Sec. 58. Minnesota Statutes 2012, section 149A.02, is amended by adding a
552.14 subdivision to read:

552.15 Subd. 12a. **Crypt.** "Crypt" means a space in a mausoleum of sufficient size, used or
552.16 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.

552.17 Sec. 59. Minnesota Statutes 2012, section 149A.02, is amended by adding a
552.18 subdivision to read:

552.19 Subd. 12b. **Direct alkaline hydrolysis.** "Direct alkaline hydrolysis" means a
552.20 final disposition of a dead human body by alkaline hydrolysis, without formal viewing,
552.21 visitation, or ceremony with the body present.

552.22 Sec. 60. Minnesota Statutes 2012, section 149A.02, subdivision 16, is amended to read:

552.23 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the
552.24 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

552.25 Sec. 61. Minnesota Statutes 2012, section 149A.02, subdivision 23, is amended to read:

552.26 Subd. 23. **Funeral services.** "Funeral services" means any services which may
552.27 be used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis,
552.28 cremation, or other final disposition; and (2) arrange, supervise, or conduct the funeral
552.29 ceremony or the final disposition of dead human bodies.

553.1 Sec. 62. Minnesota Statutes 2012, section 149A.02, is amended by adding a
553.2 subdivision to read:

553.3 Subd. 24b. **Hydrolyzed remains.** "Hydrolyzed remains" means the remains of a
553.4 dead human body following the alkaline hydrolysis process. Hydrolyzed remains does not
553.5 include pacemakers, prostheses, or similar foreign materials.

553.6 Sec. 63. Minnesota Statutes 2012, section 149A.02, is amended by adding a
553.7 subdivision to read:

553.8 Subd. 24c. **Hydrolyzed remains container.** "Hydrolyzed remains container" means
553.9 a receptacle in which hydrolyzed remains are placed. For purposes of this chapter, a
553.10 hydrolyzed remains container is interchangeable with "urn" or similar keepsake storage
553.11 jewelry.

553.12 Sec. 64. Minnesota Statutes 2012, section 149A.02, is amended by adding a
553.13 subdivision to read:

553.14 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains
553.15 in a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.

553.16 Sec. 65. Minnesota Statutes 2012, section 149A.02, subdivision 27, is amended to read:

553.17 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued
553.18 a license to practice mortuary science, to operate a funeral establishment, to operate an
553.19 alkaline hydrolysis facility, or to operate a crematory by the Minnesota commissioner
553.20 of health.

553.21 Sec. 66. Minnesota Statutes 2012, section 149A.02, is amended by adding a
553.22 subdivision to read:

553.23 Subd. 30a. **Niche.** "Niche" means a space in a columbarium used, or intended to be
553.24 used, for the placement of hydrolyzed or cremated remains.

553.25 Sec. 67. Minnesota Statutes 2012, section 149A.02, is amended by adding a
553.26 subdivision to read:

553.27 Subd. 32a. **Placement.** "Placement" means the placing of a container holding
553.28 hydrolyzed or cremated remains in a crypt, vault, or niche.

553.29 Sec. 68. Minnesota Statutes 2012, section 149A.02, subdivision 34, is amended to read:

554.1 Subd. 34. **Preparation of the body.** "Preparation of the body" means placement of
554.2 the body into an appropriate cremation or alkaline hydrolysis container, embalming of
554.3 the body or such items of care as washing, disinfecting, shaving, positioning of features,
554.4 restorative procedures, application of cosmetics, dressing, and casketing.

554.5 Sec. 69. Minnesota Statutes 2012, section 149A.02, subdivision 35, is amended to read:

554.6 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or
554.7 cooling, and the reduction of the hydrolyzed or cremated remains by mechanical means
554.8 including, but not limited to, grinding, crushing, or pulverizing, to a granulated appearance
554.9 appropriate for final disposition.

554.10 Sec. 70. Minnesota Statutes 2012, section 149A.02, subdivision 37, is amended to read:

554.11 Subd. 37. **Public transportation.** "Public transportation" means all manner of
554.12 transportation via common carrier available to the general public including airlines, buses,
554.13 railroads, and ships. For purposes of this chapter, a livery service providing transportation
554.14 to private funeral establishments, alkaline hydrolysis facilities, or crematories is not public
554.15 transportation.

554.16 Sec. 71. Minnesota Statutes 2012, section 149A.02, is amended by adding a
554.17 subdivision to read:

554.18 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed
554.19 or cremated remains in a defined area of a dedicated cemetery or in areas where no local
554.20 prohibition exists provided that the hydrolyzed or cremated remains are not distinguishable
554.21 to the public, are not in a container, and that the person who has control over disposition
554.22 of the hydrolyzed or cremated remains has obtained written permission of the property
554.23 owner or governing agency to scatter on the property.

554.24 Sec. 72. Minnesota Statutes 2012, section 149A.02, is amended by adding a
554.25 subdivision to read:

554.26 Subd. 41. **Vault.** "Vault" means a space in a mausoleum of sufficient size, used or
554.27 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.
554.28 Vault may also mean a sealed and lined casket enclosure.

554.29 Sec. 73. Minnesota Statutes 2012, section 149A.03, is amended to read:

554.30 **149A.03 DUTIES OF COMMISSIONER.**

554.31 The commissioner shall:

- 555.1 (1) enforce all laws and adopt and enforce rules relating to the:
- 555.2 (i) removal, preparation, transportation, arrangements for disposition, and final
- 555.3 disposition of dead human bodies;
- 555.4 (ii) licensure and professional conduct of funeral directors, morticians, interns,
- 555.5 practicum students, and clinical students;
- 555.6 (iii) licensing and operation of a funeral establishment; ~~and~~
- 555.7 (iv) licensing and operation of an alkaline hydrolysis facility; and
- 555.8 ~~(iv)~~ (v) licensing and operation of a crematory;
- 555.9 (2) provide copies of the requirements for licensure and permits to all applicants;
- 555.10 (3) administer examinations and issue licenses and permits to qualified persons
- 555.11 and other legal entities;
- 555.12 (4) maintain a record of the name and location of all current licensees and interns;
- 555.13 (5) perform periodic compliance reviews and premise inspections of licensees;
- 555.14 (6) accept and investigate complaints relating to conduct governed by this chapter;
- 555.15 (7) maintain a record of all current preneed arrangement trust accounts;
- 555.16 (8) maintain a schedule of application, examination, permit, and licensure fees,
- 555.17 initial and renewal, sufficient to cover all necessary operating expenses;
- 555.18 (9) educate the public about the existence and content of the laws and rules for
- 555.19 mortuary science licensing and the removal, preparation, transportation, arrangements
- 555.20 for disposition, and final disposition of dead human bodies to enable consumers to file
- 555.21 complaints against licensees and others who may have violated those laws or rules;
- 555.22 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary
- 555.23 science in order to refine the standards for licensing and to improve the regulatory and
- 555.24 enforcement methods used; and
- 555.25 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in
- 555.26 the laws, rules, or procedures governing the practice of mortuary science and the removal,
- 555.27 preparation, transportation, arrangements for disposition, and final disposition of dead
- 555.28 human bodies.

555.29 Sec. 74. **[149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS**

555.30 **FACILITY.**

555.31 Subdivision 1. License requirement. Except as provided in section 149A.01,

555.32 subdivision 3, a place or premise shall not be maintained, managed, or operated which

555.33 is devoted to or used in the holding and alkaline hydrolysis of a dead human body

555.34 without possessing a valid license to operate an alkaline hydrolysis facility issued by the

555.35 commissioner of health.

556.1 Subd. 2. Requirements for an alkaline hydrolysis facility. (a) An alkaline
556.2 hydrolysis facility licensed under this section must consist of:

556.3 (1) a building or structure that complies with applicable local and state building
556.4 codes, zoning laws and ordinances, and wastewater management and environmental
556.5 standards, containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of
556.6 dead human bodies;

556.7 (2) a method approved by the commissioner of health to dry the hydrolyzed remains
556.8 and which is located within the licensed facility;

556.9 (3) a means approved by the commissioner of health for refrigeration of dead human
556.10 bodies awaiting alkaline hydrolysis;

556.11 (4) an appropriate means of processing hydrolyzed remains to a granulated
556.12 appearance appropriate for final disposition; and

556.13 (5) an appropriate holding facility for dead human bodies awaiting alkaline
556.14 hydrolysis.

556.15 (b) An alkaline hydrolysis facility licensed under this section may also contain a
556.16 display room for funeral goods.

556.17 Subd. 3. Application procedure; documentation; initial inspection. An
556.18 application to license and operate an alkaline hydrolysis facility shall be submitted to the
556.19 commissioner of health. A completed application includes:

556.20 (1) a completed application form, as provided by the commissioner;

556.21 (2) proof of business form and ownership;

556.22 (3) proof of liability insurance coverage or other financial documentation, as
556.23 determined by the commissioner, that demonstrates the applicant's ability to respond in
556.24 damages for liability arising from the ownership, maintenance management, or operation
556.25 of an alkaline hydrolysis facility; and

556.26 (4) copies of wastewater and other environmental regulatory permits and
556.27 environmental regulatory licenses necessary to conduct operations.

556.28 Upon receipt of the application and appropriate fee, the commissioner shall review and
556.29 verify all information. Upon completion of the verification process and resolution of any

556.30 deficiencies in the application information, the commissioner shall conduct an initial
556.31 inspection of the premises to be licensed. After the inspection and resolution of any

556.32 deficiencies found and any reinspections as may be necessary, the commissioner shall

556.33 make a determination, based on all the information available, to grant or deny licensure. If

556.34 the commissioner's determination is to grant the license, the applicant shall be notified and

556.35 the license shall issue and remain valid for a period prescribed on the license, but not to

556.36 exceed one calendar year from the date of issuance of the license. If the commissioner's

557.1 determination is to deny the license, the commissioner must notify the applicant in writing
557.2 of the denial and provide the specific reason for denial.

557.3 Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis
557.4 facility is not assignable or transferable and shall not be valid for any entity other than the
557.5 one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the
557.6 location identified on the license. A 50 percent or more change in ownership or location of
557.7 the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall
557.8 be required of two or more persons or other legal entities operating from the same location.

557.9 Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis
557.10 facility must be conspicuously displayed in the alkaline hydrolysis facility at all times.
557.11 Conspicuous display means in a location where a member of the general public within the
557.12 alkaline hydrolysis facility is able to observe and read the license.

557.13 Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility
557.14 issued by the commissioner are valid for a period of one calendar year beginning on July 1
557.15 and ending on June 30, regardless of the date of issuance.

557.16 Subd. 7. **Reporting changes in license information.** Any change of license
557.17 information must be reported to the commissioner, on forms provided by the
557.18 commissioner, no later than 30 calendar days after the change occurs. Failure to report
557.19 changes is grounds for disciplinary action.

557.20 Subd. 8. **Notification to the commissioner.** If the licensee is operating under a
557.21 wastewater or an environmental permit or license that is subsequently revoked, denied,
557.22 or terminated, the licensee shall notify the commissioner.

557.23 Subd. 9. **Application information.** All information submitted to the commissioner
557.24 for a license to operate an alkaline hydrolysis facility is classified as licensing data under
557.25 section 13.41, subdivision 5.

557.26 Sec. 75. **[149A.55] RENEWAL OF LICENSE TO OPERATE AN ALKALINE**
557.27 **HYDROLYSIS FACILITY.**

557.28 Subdivision 1. **Renewal required.** All licenses to operate an alkaline hydrolysis
557.29 facility issued by the commissioner expire on June 30 following the date of issuance of the
557.30 license and must be renewed to remain valid.

557.31 Subd. 2. **Renewal procedure and documentation.** Licensees who wish to renew
557.32 their licenses must submit to the commissioner a completed renewal application no later
557.33 than June 30 following the date the license was issued. A completed renewal application
557.34 includes:

557.35 (1) a completed renewal application form, as provided by the commissioner; and

558.1 (2) proof of liability insurance coverage or other financial documentation, as
558.2 determined by the commissioner, that demonstrates the applicant's ability to respond in
558.3 damages for liability arising from the ownership, maintenance, management, or operation
558.4 of an alkaline hydrolysis facility.

558.5 Upon receipt of the completed renewal application, the commissioner shall review and
558.6 verify the information. Upon completion of the verification process and resolution of
558.7 any deficiencies in the renewal application information, the commissioner shall make a
558.8 determination, based on all the information available, to reissue or refuse to reissue the
558.9 license. If the commissioner's determination is to reissue the license, the applicant shall
558.10 be notified and the license shall issue and remain valid for a period prescribed on the
558.11 license, but not to exceed one calendar year from the date of issuance of the license. If
558.12 the commissioner's determination is to refuse to reissue the license, section 149A.09,
558.13 subdivision 2, applies.

558.14 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration
558.15 date of a license will result in the assessment of a late filing penalty. The late filing penalty
558.16 must be paid before the reissuance of the license and received by the commissioner no
558.17 later than 31 calendar days after the expiration date of the license.

558.18 Subd. 4. **Lapse of license.** Licenses to operate alkaline hydrolysis facilities
558.19 shall automatically lapse when a completed renewal application is not received by the
558.20 commissioner within 31 calendar days after the expiration date of a license, or a late
558.21 filing penalty assessed under subdivision 3 is not received by the commissioner within 31
558.22 calendar days after the expiration of a license.

558.23 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom
558.24 the license was issued is no longer licensed to operate an alkaline hydrolysis facility in
558.25 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed
558.26 license holder from operating an alkaline hydrolysis facility in Minnesota and may pursue
558.27 any additional lawful remedies as justified by the case.

558.28 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed
558.29 license upon receipt and review of a completed renewal application, receipt of the late
558.30 filing penalty, and reinspection of the premises, provided that the receipt is made within
558.31 one calendar year from the expiration date of the lapsed license and the cease and desist
558.32 order issued by the commissioner has not been violated. If a lapsed license is not restored
558.33 within one calendar year from the expiration date of the lapsed license, the holder of the
558.34 lapsed license cannot be relicensed until the requirements in section 149A.54 are met.

558.35 Subd. 7. **Reporting changes in license information.** Any change of license
558.36 information must be reported to the commissioner, on forms provided by the

559.1 commissioner, no later than 30 calendar days after the change occurs. Failure to report
559.2 changes is grounds for disciplinary action.

559.3 Subd. 8. **Application information.** All information submitted to the commissioner
559.4 by an applicant for renewal of licensure to operate an alkaline hydrolysis facility is
559.5 classified as licensing data under section 13.41, subdivision 5.

559.6 Sec. 76. Minnesota Statutes 2012, section 149A.65, is amended by adding a
559.7 subdivision to read:

559.8 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline
559.9 hydrolysis facility is \$300. The late fee charge for a license renewal is \$25.

559.10 Sec. 77. Minnesota Statutes 2012, section 149A.65, is amended by adding a
559.11 subdivision to read:

559.12 Subd. 7. **State government special revenue fund.** Fees collected by the
559.13 commissioner under this section must be deposited in the state treasury and credited to
559.14 the state government special revenue fund.

559.15 Sec. 78. Minnesota Statutes 2012, section 149A.70, subdivision 1, is amended to read:

559.16 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice
559.17 mortuary science issued by the commissioner may use the title of mortician, funeral
559.18 director, or any other title implying that the licensee is engaged in the business or practice
559.19 of mortuary science. Only the holder of a valid license to operate an alkaline hydrolysis
559.20 facility issued by the commissioner may use the title of alkaline hydrolysis facility, water
559.21 cremation, water-reduction, biocremation, green-cremation, resomation, dissolution, or
559.22 any other title, word, or term implying that the licensee operates an alkaline hydrolysis
559.23 facility. Only the holder of a valid license to operate a funeral establishment issued by the
559.24 commissioner may use the title of funeral home, funeral chapel, funeral service, or any
559.25 other title, word, or term implying that the licensee is engaged in the business or practice
559.26 of mortuary science. Only the holder of a valid license to operate a crematory issued by
559.27 the commissioner may use the title of crematory, crematorium, green-cremation, or any
559.28 other title, word, or term implying that the licensee operates a crematory or crematorium.

559.29 Sec. 79. Minnesota Statutes 2012, section 149A.70, subdivision 2, is amended to read:

559.30 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, or
559.31 crematory shall not do business in a location that is not licensed as a funeral establishment,

560.1 alkaline hydrolysis facility, or crematory and shall not advertise a service that is available
560.2 from an unlicensed location.

560.3 Sec. 80. Minnesota Statutes 2012, section 149A.70, subdivision 3, is amended to read:

560.4 Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern
560.5 shall publish or disseminate false, misleading, or deceptive advertising. False, misleading,
560.6 or deceptive advertising includes, but is not limited to:

560.7 (1) identifying, by using the names or pictures of, persons who are not licensed to
560.8 practice mortuary science in a way that leads the public to believe that those persons will
560.9 provide mortuary science services;

560.10 (2) using any name other than the names under which the funeral establishment,
560.11 alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;

560.12 (3) using a surname not directly, actively, or presently associated with a licensed
560.13 funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had
560.14 been previously and continuously used by the licensed funeral establishment, alkaline
560.15 hydrolysis facility, or crematory; and

560.16 (4) using a founding or establishing date or total years of service not directly or
560.17 continuously related to a name under which the funeral establishment, alkaline hydrolysis
560.18 facility, or crematory is currently or was previously licensed.

560.19 Any advertising or other printed material that contains the names or pictures of
560.20 persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory
560.21 shall state the position held by the persons and shall identify each person who is licensed
560.22 or unlicensed under this chapter.

560.23 Sec. 81. Minnesota Statutes 2012, section 149A.70, subdivision 5, is amended to read:

560.24 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum
560.25 student, or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other
560.26 reimbursement in consideration for recommending or causing a dead human body to
560.27 be disposed of by a specific body donation program, funeral establishment, alkaline
560.28 hydrolysis facility, crematory, mausoleum, or cemetery.

560.29 Sec. 82. Minnesota Statutes 2012, section 149A.71, subdivision 2, is amended to read:

560.30 Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or
560.31 practices, the requirements of this subdivision must be met.

560.32 (b) Funeral providers must tell persons who ask by telephone about the funeral
560.33 provider's offerings or prices any accurate information from the price lists described in

561.1 paragraphs (c) to (e) and any other readily available information that reasonably answers
561.2 the questions asked.

561.3 (c) Funeral providers must make available for viewing to people who inquire in
561.4 person about the offerings or prices of funeral goods or burial site goods, separate printed
561.5 or typewritten price lists using a ten-point font or larger. Each funeral provider must have a
561.6 separate price list for each of the following types of goods that are sold or offered for sale:

- 561.7 (1) caskets;
- 561.8 (2) alternative containers;
- 561.9 (3) outer burial containers;
- 561.10 (4) alkaline hydrolysis containers;
- 561.11 ~~(4)~~ (5) cremation containers;
- 561.12 (6) hydrolyzed remains containers;
- 561.13 ~~(5)~~ (7) cremated remains containers;
- 561.14 ~~(6)~~ (8) markers; and
- 561.15 ~~(7)~~ (9) headstones.

561.16 (d) Each separate price list must contain the name of the funeral provider's place
561.17 of business, address, and telephone number and a caption describing the list as a price
561.18 list for one of the types of funeral goods or burial site goods described in paragraph (c),
561.19 clauses (1) to ~~(7)~~ (9). The funeral provider must offer the list upon beginning discussion
561.20 of, but in any event before showing, the specific funeral goods or burial site goods and
561.21 must provide a photocopy of the price list, for retention, if so asked by the consumer. The
561.22 list must contain, at least, the retail prices of all the specific funeral goods and burial site
561.23 goods offered which do not require special ordering, enough information to identify each,
561.24 and the effective date for the price list. However, funeral providers are not required to
561.25 make a specific price list available if the funeral providers place the information required
561.26 by this paragraph on the general price list described in paragraph (e).

561.27 (e) Funeral providers must give a printed price list, for retention, to persons who
561.28 inquire in person about the funeral goods, funeral services, burial site goods, or burial site
561.29 services or prices offered by the funeral provider. The funeral provider must give the list
561.30 upon beginning discussion of either the prices of or the overall type of funeral service or
561.31 disposition or specific funeral goods, funeral services, burial site goods, or burial site
561.32 services offered by the provider. This requirement applies whether the discussion takes
561.33 place in the funeral establishment or elsewhere. However, when the deceased is removed
561.34 for transportation to the funeral establishment, an in-person request for authorization to
561.35 embalm does not, by itself, trigger the requirement to offer the general price list. If the
561.36 provider, in making an in-person request for authorization to embalm, discloses that

562.1 embalming is not required by law except in certain special cases, the provider is not
562.2 required to offer the general price list. Any other discussion during that time about prices
562.3 or the selection of funeral goods, funeral services, burial site goods, or burial site services
562.4 triggers the requirement to give the consumer a general price list. The general price list
562.5 must contain the following information:

562.6 (1) the name, address, and telephone number of the funeral provider's place of
562.7 business;

562.8 (2) a caption describing the list as a "general price list";

562.9 (3) the effective date for the price list;

562.10 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per
562.11 hour, mile, or other unit of computation, and other information described as follows:

562.12 (i) forwarding of remains to another funeral establishment, together with a list of
562.13 the services provided for any quoted price;

562.14 (ii) receiving remains from another funeral establishment, together with a list of
562.15 the services provided for any quoted price;

562.16 (iii) separate prices for each alkaline hydrolysis or cremation offered by the funeral
562.17 provider, with the price including an alternative container or alkaline hydrolysis or
562.18 cremation container, any alkaline hydrolysis or crematory charges, and a description of the
562.19 services and container included in the price, where applicable, and the price of alkaline
562.20 hydrolysis or cremation where the purchaser provides the container;

562.21 (iv) separate prices for each immediate burial offered by the funeral provider,
562.22 including a casket or alternative container, and a description of the services and container
562.23 included in that price, and the price of immediate burial where the purchaser provides the
562.24 casket or alternative container;

562.25 (v) transfer of remains to the funeral establishment or other location;

562.26 (vi) embalming;

562.27 (vii) other preparation of the body;

562.28 (viii) use of facilities, equipment, or staff for viewing;

562.29 (ix) use of facilities, equipment, or staff for funeral ceremony;

562.30 (x) use of facilities, equipment, or staff for memorial service;

562.31 (xi) use of equipment or staff for graveside service;

562.32 (xii) hearse or funeral coach;

562.33 (xiii) limousine; and

562.34 (xiv) separate prices for all cemetery-specific goods and services, including all goods
562.35 and services associated with interment and burial site goods and services and excluding
562.36 markers and headstones;

563.1 (5) the price range for the caskets offered by the funeral provider, together with the
563.2 statement "A complete price list will be provided at the funeral establishment or casket
563.3 sale location." or the prices of individual caskets, as disclosed in the manner described
563.4 in paragraphs (c) and (d);

563.5 (6) the price range for the alternative containers offered by the funeral provider,
563.6 together with the statement "A complete price list will be provided at the funeral
563.7 establishment or alternative container sale location." or the prices of individual alternative
563.8 containers, as disclosed in the manner described in paragraphs (c) and (d);

563.9 (7) the price range for the outer burial containers offered by the funeral provider,
563.10 together with the statement "A complete price list will be provided at the funeral
563.11 establishment or outer burial container sale location." or the prices of individual outer
563.12 burial containers, as disclosed in the manner described in paragraphs (c) and (d);

563.13 (8) the price range for the alkaline hydrolysis container offered by the funeral
563.14 provider, together with the statement: "A complete price list will be provided at the funeral
563.15 establishment or alkaline hydrolysis container sale location.", or the prices of individual
563.16 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c)
563.17 and (d);

563.18 (9) the price range for the hydrolyzed remains container offered by the funeral
563.19 provider, together with the statement: "A complete price list will be provided at the
563.20 funeral establishment or hydrolyzed remains container sale location.", or the prices
563.21 of individual hydrolyzed remains container, as disclosed in the manner described in
563.22 paragraphs (c) and (d);

563.23 ~~(8)~~ (10) the price range for the cremation containers offered by the funeral provider,
563.24 together with the statement "A complete price list will be provided at the funeral
563.25 establishment or cremation container sale location." or the prices of individual cremation
563.26 containers ~~and cremated remains containers~~, as disclosed in the manner described in
563.27 paragraphs (c) and (d);

563.28 (9) (11) the price range for the cremated remains containers offered by the funeral
563.29 provider, together with the statement, "A complete price list will be provided at the funeral
563.30 establishment or ~~cremation~~ cremated remains container sale location," or the prices of
563.31 individual cremation containers as disclosed in the manner described in paragraphs (c)
563.32 and (d);

563.33 ~~(10)~~ (12) the price for the basic services of funeral provider and staff, together with a
563.34 list of the principal basic services provided for any quoted price and, if the charge cannot
563.35 be declined by the purchaser, the statement "This fee for our basic services will be added
563.36 to the total cost of the funeral arrangements you select. (This fee is already included in

564.1 our charges for alkaline hydrolysis, direct cremations, immediate burials, and forwarding
564.2 or receiving remains.)" If the charge cannot be declined by the purchaser, the quoted
564.3 price shall include all charges for the recovery of unallocated funeral provider overhead,
564.4 and funeral providers may include in the required disclosure the phrase "and overhead"
564.5 after the word "services." This services fee is the only funeral provider fee for services,
564.6 facilities, or unallocated overhead permitted by this subdivision to be nondeclinable,
564.7 unless otherwise required by law;

564.8 ~~(11)~~ (13) the price range for the markers and headstones offered by the funeral
564.9 provider, together with the statement "A complete price list will be provided at the funeral
564.10 establishment or marker or headstone sale location." or the prices of individual markers
564.11 and headstones, as disclosed in the manner described in paragraphs (c) and (d); and

564.12 ~~(12)~~ (14) any package priced funerals offered must be listed in addition to and
564.13 following the information required in paragraph (e) and must clearly state the funeral
564.14 goods and services being offered, the price being charged for those goods and services,
564.15 and the discounted savings.

564.16 (f) Funeral providers must give an itemized written statement, for retention, to each
564.17 consumer who arranges an at-need funeral or other disposition of human remains at the
564.18 conclusion of the discussion of the arrangements. The itemized written statement must be
564.19 signed by the consumer selecting the goods and services as required in section 149A.80.
564.20 If the statement is provided by a funeral establishment, the statement must be signed by
564.21 the licensed funeral director or mortician planning the arrangements. If the statement is
564.22 provided by any other funeral provider, the statement must be signed by an authorized
564.23 agent of the funeral provider. The statement must list the funeral goods, funeral services,
564.24 burial site goods, or burial site services selected by that consumer and the prices to be paid
564.25 for each item, specifically itemized cash advance items (these prices must be given to the
564.26 extent then known or reasonably ascertainable if the prices are not known or reasonably
564.27 ascertainable, a good faith estimate shall be given and a written statement of the actual
564.28 charges shall be provided before the final bill is paid), and the total cost of goods and
564.29 services selected. At the conclusion of an at-need arrangement, the funeral provider is
564.30 required to give the consumer a copy of the signed itemized written contract that must
564.31 contain the information required in this paragraph.

564.32 (g) Upon receiving actual notice of the death of an individual with whom a funeral
564.33 provider has entered a preneed funeral agreement, the funeral provider must provide
564.34 a copy of all preneed funeral agreement documents to the person who controls final
564.35 disposition of the human remains or to the designee of the person controlling disposition.
564.36 The person controlling final disposition shall be provided with these documents at the time

565.1 of the person's first in-person contact with the funeral provider, if the first contact occurs
565.2 in person at a funeral establishment, alkaline hydrolysis facility, crematory, or other place
565.3 of business of the funeral provider. If the contact occurs by other means or at another
565.4 location, the documents must be provided within 24 hours of the first contact.

565.5 Sec. 83. Minnesota Statutes 2012, section 149A.71, subdivision 4, is amended to read:

565.6 Subd. 4. **Casket, alternate container, alkaline hydrolysis container, and**
565.7 **cremation container sales; records; required disclosures.** Any funeral provider who
565.8 sells or offers to sell a casket, alternate container, ~~or alkaline hydrolysis container,~~
565.9 hydrolyzed remains container, cremation container, or cremated remains container to
565.10 the public must maintain a record of each sale that includes the name of the purchaser,
565.11 the purchaser's mailing address, the name of the decedent, the date of the decedent's
565.12 death, and the place of death. These records shall be open to inspection by the regulatory
565.13 agency. Any funeral provider selling a casket, alternate container, or cremation container
565.14 to the public, and not having charge of the final disposition of the dead human body,
565.15 shall provide a copy of the statutes and rules controlling the removal, preparation,
565.16 transportation, arrangements for disposition, and final disposition of a dead human body.
565.17 This subdivision does not apply to morticians, funeral directors, funeral establishments,
565.18 crematories, or wholesale distributors of caskets, alternate containers, alkaline hydrolysis
565.19 containers, or cremation containers.

565.20 Sec. 84. Minnesota Statutes 2012, section 149A.72, subdivision 3, is amended to read:

565.21 Subd. 3. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts**
565.22 **or practices.** In selling or offering to sell funeral goods or funeral services to the public, it
565.23 is a deceptive act or practice for a funeral provider to represent that a casket is required for
565.24 alkaline hydrolysis or cremations by state or local law or otherwise.

565.25 Sec. 85. Minnesota Statutes 2012, section 149A.72, is amended by adding a
565.26 subdivision to read:

565.27 Subd. 3a. **Casket for alkaline hydrolysis provision; preventive measures.** To
565.28 prevent deceptive acts or practices, funeral providers must place the following disclosure
565.29 in immediate conjunction with the prices shown for alkaline hydrolysis: "Minnesota
565.30 law does not require you to purchase a casket for alkaline hydrolysis. If you want to
565.31 arrange for alkaline hydrolysis, you can use an alkaline hydrolysis container. An alkaline
565.32 hydrolysis container is a hydrolyzable or biodegradable closed container or pouch resistant
565.33 to leakage of bodily fluids that encases the body and into which a dead human body is

566.1 placed prior to insertion into an alkaline hydrolysis vessel. The containers we provide
566.2 are (specify containers provided)." This disclosure is required only if the funeral provider
566.3 arranges alkaline hydrolysis.

566.4 Sec. 86. Minnesota Statutes 2012, section 149A.72, subdivision 9, is amended to read:

566.5 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods,
566.6 funeral services, burial site goods, or burial site services to the public, it is a deceptive act
566.7 or practice for a funeral provider to represent that federal, state, or local laws, or particular
566.8 cemeteries, alkaline hydrolysis facilities, or crematories, require the purchase of any funeral
566.9 goods, funeral services, burial site goods, or burial site services when that is not the case.

566.10 Sec. 87. Minnesota Statutes 2012, section 149A.73, subdivision 1, is amended to read:

566.11 Subdivision 1. **Casket for alkaline hydrolysis or cremation provisions; deceptive**
566.12 **acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site
566.13 goods, or burial site services to the public, it is a deceptive act or practice for a funeral
566.14 provider to require that a casket be purchased for alkaline hydrolysis or cremation.

566.15 Sec. 88. Minnesota Statutes 2012, section 149A.73, subdivision 2, is amended to read:

566.16 Subd. 2. **Casket for alkaline hydrolysis or cremation; preventive requirements.**
566.17 To prevent unfair or deceptive acts or practices, if funeral providers arrange for alkaline
566.18 hydrolysis or cremations, they must make a an alkaline hydrolysis container or cremation
566.19 container available for alkaline hydrolysis or cremations.

566.20 Sec. 89. Minnesota Statutes 2012, section 149A.73, subdivision 4, is amended to read:

566.21 Subd. 4. **Required purchases of funeral goods or services; preventive**
566.22 **requirements.** To prevent unfair or deceptive acts or practices, funeral providers must
566.23 place the following disclosure in the general price list, immediately above the prices
566.24 required by section 149A.71, subdivision 2, paragraph (e), clauses (4) to (10): "The goods
566.25 and services shown below are those we can provide to our customers. You may choose
566.26 only the items you desire. If legal or other requirements mean that you must buy any items
566.27 you did not specifically ask for, we will explain the reason in writing on the statement we
566.28 provide describing the funeral goods, funeral services, burial site goods, and burial site
566.29 services you selected." However, if the charge for "services of funeral director and staff"
566.30 cannot be declined by the purchaser, the statement shall include the sentence "However,
566.31 any funeral arrangements you select will include a charge for our basic services." between
566.32 the second and third sentences of the sentences specified in this subdivision. The statement

567.1 may include the phrase "and overhead" after the word "services" if the fee includes a
567.2 charge for the recovery of unallocated funeral overhead. If the funeral provider does
567.3 not include this disclosure statement, then the following disclosure statement must be
567.4 placed in the statement of funeral goods, funeral services, burial site goods, and burial site
567.5 services selected, as described in section 149A.71, subdivision 2, paragraph (f): "Charges
567.6 are only for those items that you selected or that are required. If we are required by law or
567.7 by a cemetery, alkaline hydrolysis facility, or crematory to use any items, we will explain
567.8 the reasons in writing below." A funeral provider is not in violation of this subdivision by
567.9 failing to comply with a request for a combination of goods or services which would be
567.10 impossible, impractical, or excessively burdensome to provide.

567.11 Sec. 90. Minnesota Statutes 2012, section 149A.74, is amended to read:

567.12 **149A.74 FUNERAL SERVICES PROVIDED WITHOUT PRIOR APPROVAL.**

567.13 Subdivision 1. **Services provided without prior approval; deceptive acts or**
567.14 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it
567.15 is a deceptive act or practice for any funeral provider to embalm a dead human body
567.16 unless state or local law or regulation requires embalming in the particular circumstances
567.17 regardless of any funeral choice which might be made, or prior approval for embalming
567.18 has been obtained from an individual legally authorized to make such a decision. In
567.19 seeking approval to embalm, the funeral provider must disclose that embalming is not
567.20 required by law except in certain circumstances; that a fee will be charged if a funeral
567.21 is selected which requires embalming, such as a funeral with viewing; and that no
567.22 embalming fee will be charged if the family selects a service which does not require
567.23 embalming, such as direct alkaline hydrolysis, direct cremation, or immediate burial.

567.24 Subd. 2. **Services provided without prior approval; preventive requirement.**

567.25 To prevent unfair or deceptive acts or practices, funeral providers must include on
567.26 the itemized statement of funeral goods or services, as described in section 149A.71,
567.27 subdivision 2, paragraph (f), the statement "If you selected a funeral that may require
567.28 embalming, such as a funeral with viewing, you may have to pay for embalming. You do
567.29 not have to pay for embalming you did not approve if you selected arrangements such
567.30 as direct alkaline hydrolysis, direct cremation, or immediate burial. If we charged for
567.31 embalming, we will explain why below."

567.32 Sec. 91. Minnesota Statutes 2012, section 149A.91, subdivision 9, is amended to read:

567.33 Subd. 9. **Embalmed Bodies awaiting final disposition.** All embalmed bodies
567.34 awaiting final disposition shall be kept in an appropriate holding facility or preparation

568.1 and embalming room. The holding facility must be secure from access by anyone except
568.2 the authorized personnel of the funeral establishment, preserve the dignity and integrity of
568.3 the body, and protect the health and safety of the personnel of the funeral establishment.

568.4 Sec. 92. Minnesota Statutes 2012, section 149A.93, subdivision 3, is amended to read:

568.5 Subd. 3. **Disposition permit.** A disposition permit is required before a body can
568.6 be buried, entombed, alkaline hydrolyzed, or cremated. No disposition permit shall be
568.7 issued until a fact of death record has been completed and filed with the local or state
568.8 registrar of vital statistics.

568.9 Sec. 93. Minnesota Statutes 2012, section 149A.93, subdivision 6, is amended to read:

568.10 Subd. 6. **Conveyances permitted for transportation.** A dead human body may be
568.11 transported by means of private vehicle or private aircraft, provided that the body must be
568.12 encased in an appropriate container, that meets the following standards:

568.13 (1) promotes respect for and preserves the dignity of the dead human body;

568.14 (2) shields the body from being viewed from outside of the conveyance;

568.15 (3) has ample enclosed area to accommodate a cot, stretcher, rigid tray, casket,
568.16 alternative container, alkaline hydrolysis container, or cremation container in a horizontal
568.17 position;

568.18 (4) is designed to permit loading and unloading of the body without excessive tilting
568.19 of the cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container,
568.20 or cremation container; and

568.21 (5) if used for the transportation of more than one dead human body at one time,
568.22 the vehicle must be designed so that a body or container does not rest directly on top of
568.23 another body or container and that each body or container is secured to prevent the body
568.24 or container from excessive movement within the conveyance.

568.25 A vehicle that is a dignified conveyance and was specified for use by the deceased
568.26 or by the family of the deceased may be used to transport the body to the place of final
568.27 disposition.

568.28 Sec. 94. Minnesota Statutes 2012, section 149A.94, is amended to read:

568.29 **149A.94 FINAL DISPOSITION.**

568.30 Subdivision 1. **Generally.** Every dead human body lying within the state, except
568.31 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
568.32 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
568.33 the state for the purpose of disposition elsewhere; and the remains of any dead human

569.1 body after dissection or anatomical study, shall be decently buried, or entombed in a
569.2 public or private cemetery, alkaline hydrolyzed or cremated, within a reasonable time
569.3 after death. Where final disposition of a body will not be accomplished within 72 hours
569.4 following death or release of the body by a competent authority with jurisdiction over the
569.5 body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body
569.6 may not be kept in refrigeration for a period exceeding six calendar days, or packed in dry
569.7 ice for a period that exceeds four calendar days, from the time of death or release of the
569.8 body from the coroner or medical examiner.

569.9 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, or
569.10 cremated without a disposition permit. The disposition permit must be filed with the person
569.11 in charge of the place of final disposition. Where a dead human body will be transported out
569.12 of this state for final disposition, the body must be accompanied by a certificate of removal.

569.13 Subd. 4. **Alkaline hydrolysis or cremation.** Inurnment of alkaline hydrolyzed or
569.14 cremated remains and release to an appropriate party is considered final disposition and no
569.15 further permits or authorizations are required for transportation, interment, entombment, or
569.16 placement of the cremated remains, except as provided in section 149A.95, subdivision 16.

569.17 Sec. 95. **[149A.941] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE**
569.18 **HYDROLYSIS.**

569.19 Subdivision 1. **License required.** A dead human body may only be hydrolyzed in
569.20 this state at an alkaline hydrolysis facility licensed by the commissioner of health.

569.21 Subd. 2. **General requirements.** Any building to be used as an alkaline hydrolysis
569.22 facility must comply with all applicable local and state building codes, zoning laws and
569.23 ordinances, wastewater management regulations, and environmental statutes, rules, and
569.24 standards. An alkaline hydrolysis facility must have, on site, a purpose built human
569.25 alkaline hydrolysis system approved by the commissioner of health, a system approved by
569.26 the commissioner of health for drying the hydrolyzed remains, a motorized mechanical
569.27 device approved by the commissioner of health for processing hydrolyzed remains, and in
569.28 the building a holding facility approved by the commissioner of health for the retention
569.29 of dead human bodies awaiting alkaline hydrolysis. The holding facility must be secure
569.30 from access by anyone except the authorized personnel of the alkaline hydrolysis facility,
569.31 preserve the dignity of the remains, and protect the health and safety of the alkaline
569.32 hydrolysis facility personnel.

569.33 Subd. 3. **Lighting and ventilation.** The room where the alkaline hydrolysis vessel
569.34 is located and the room where the chemical storage takes place shall be properly lit and
569.35 ventilated with an exhaust fan that provides at least 12 air changes per hour.

570.1 Subd. 4. **Plumbing connections.** All plumbing fixtures, water supply lines,
570.2 plumbing vents, and waste drains shall be properly vented and connected pursuant to the
570.3 Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a
570.4 functional sink with hot and cold running water.

570.5 Subd. 5. **Flooring, walls, ceiling, doors, and windows.** The room where the
570.6 alkaline hydrolysis vessel is located and the room where the chemical storage takes place
570.7 shall have nonporous flooring, so that a sanitary condition is provided. The walls and
570.8 ceiling of the room where the alkaline hydrolysis vessel is located and the room where
570.9 the chemical storage takes place shall run from floor to ceiling and be covered with tile,
570.10 or by plaster or sheetrock painted with washable paint or other appropriate material so
570.11 that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be
570.12 constructed to prevent odors from entering any other part of the building. All windows
570.13 or other openings to the outside must be screened, and all windows must be treated in a
570.14 manner that prevents viewing into the room where the alkaline hydrolysis vessel is located
570.15 and the room where the chemical storage takes place. A viewing window for authorized
570.16 family members or their designees is not a violation of this subdivision.

570.17 Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a
570.18 functional emergency eye wash and quick drench shower.

570.19 Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is
570.20 located and the room where the chemical storage takes place must be private and have no
570.21 general passageway through it. The room shall, at all times, be secure from the entrance of
570.22 unauthorized persons. Authorized persons are:

570.23 (1) licensed morticians;

570.24 (2) registered interns or students as described in section 149A.91, subdivision 6;

570.25 (3) public officials or representatives in the discharge of their official duties;

570.26 (4) trained alkaline hydrolysis facility operators; and

570.27 (5) the person or persons with the right to control the dead human body as defined in
570.28 section 149A.80, subdivision 2, and their designees.

570.29 (b) Each door allowing ingress or egress shall carry a sign that indicates that the
570.30 room is private and access is limited. All authorized persons who are present in or enter
570.31 the room where the alkaline hydrolysis vessel is located while a body is being prepared for
570.32 final disposition must be attired according to all applicable state and federal regulations
570.33 regarding the control of infectious disease and occupational and workplace health and
570.34 safety.

570.35 Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline
570.36 hydrolysis vessel is located and the room where the chemical storage takes place and all

571.1 fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies
571.2 stored or used in the room must be maintained in a clean and sanitary condition at all times.

571.3 Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline
571.4 hydrolysis vessel for its operation, all state and local regulations for that boiler must be
571.5 followed.

571.6 Subd. 10. **Occupational and workplace safety.** All applicable provisions of state
571.7 and federal regulations regarding exposure to workplace hazards and accidents shall be
571.8 followed in order to protect the health and safety of all authorized persons at the alkaline
571.9 hydrolysis facility.

571.10 Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ
571.11 a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body.
571.12 It is the duty of the licensed alkaline hydrolysis facility to provide proper procedures for
571.13 all personnel, and the licensed alkaline hydrolysis facility shall be strictly accountable for
571.14 compliance with this chapter and other applicable state and federal regulations regarding
571.15 occupational and workplace health and safety.

571.16 Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility
571.17 shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part
571.18 without receiving written authorization to do so from the person or persons who have the
571.19 legal right to control disposition as described in section 149A.80 or the person's legal
571.20 designee. The written authorization must include:

571.21 (1) the name of the deceased and the date of death of the deceased;

571.22 (2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;

571.23 (3) the name, address, telephone number, relationship to the deceased, and signature
571.24 of the person or persons with legal right to control final disposition or a legal designee;

571.25 (4) directions for the disposition of any nonhydrolyzed materials or items recovered
571.26 from the alkaline hydrolysis vessel;

571.27 (5) acknowledgment that the hydrolyzed remains will be dried and mechanically
571.28 reduced to a granulated appearance and placed in an appropriate container and

571.29 authorization to place any hydrolyzed remains that a selected urn or container will not
571.30 accommodate into a temporary container;

571.31 (6) acknowledgment that, even with the exercise of reasonable care, it is not possible
571.32 to recover all particles of the hydrolyzed remains and that some particles may inadvertently
571.33 become commingled with particles of other hydrolyzed remains that remain in the alkaline
571.34 hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;

571.35 (7) directions for the ultimate disposition of the hydrolyzed remains; and

572.1 (8) a statement that includes, but is not limited to, the following information:
572.2 "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an
572.3 alkaline solution is used to chemically break down the human tissue and the hydrolyzable
572.4 alkaline hydrolysis container. After the process is complete, the liquid effluent solution
572.5 contains the chemical by-products of the alkaline hydrolysis process except for the
572.6 deceased's bone fragments. The solution is cooled and released according to local
572.7 environmental regulations. A water rinse is applied to the hydrolyzed remains which are
572.8 then dried and processed to facilitate inurnment or scattering."

572.9 Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in
572.10 good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an
572.11 authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from
572.12 civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis
572.13 facility.

572.14 Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be
572.15 accepted for final disposition by alkaline hydrolysis unless:

572.16 (1) encased in an appropriate alkaline hydrolysis container;

572.17 (2) accompanied by a disposition permit issued pursuant to section 149A.93,
572.18 subdivision 3, including a photocopy of the completed death record or a signed release
572.19 authorizing alkaline hydrolysis of the body received from the coroner or medical
572.20 examiner; and

572.21 (3) accompanied by an alkaline hydrolysis authorization that complies with
572.22 subdivision 12.

572.23 (b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline
572.24 hydrolysis container where there is:

572.25 (1) evidence of leakage of fluids from the alkaline hydrolysis container;

572.26 (2) a known dispute concerning hydrolysis of the body delivered;

572.27 (3) a reasonable basis for questioning any of the representations made on the written
572.28 authorization to hydrolyze; or

572.29 (4) any other lawful reason.

572.30 Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed
572.31 within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of
572.32 the body.

572.33 Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.**

572.34 All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for
572.35 dead human bodies shall use universal precautions and otherwise exercise all reasonable

573.1 precautions to minimize the risk of transmitting any communicable disease from the body.

573.2 No dead human body shall be removed from the container in which it is delivered.

573.3 Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall

573.4 develop, implement, and maintain an identification procedure whereby dead human

573.5 bodies can be identified from the time the alkaline hydrolysis facility accepts delivery

573.6 of the remains until the hydrolyzed remains are released to an authorized party. After

573.7 hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the

573.8 hydrolyzed remains container before the hydrolyzed remains are released from the alkaline

573.9 hydrolysis facility. Each identification disk, tab, or label shall have a number that shall

573.10 be recorded on all paperwork regarding the decedent. This procedure shall be designed

573.11 to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains

573.12 are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the

573.13 inability to individually identify the hydrolyzed remains is a violation of this subdivision.

573.14 Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline

573.15 hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains

573.16 in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for

573.17 infectious disease control.

573.18 Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of

573.19 dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is

573.20 written authorization from the person with the legal right to control the disposition,

573.21 only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline

573.22 hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting

573.23 alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline

573.24 hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.

573.25 Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains**

573.26 **prohibited.** Except with the express written permission of the person with the legal right

573.27 to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one

573.28 dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce

573.29 a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have

573.30 been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze

573.31 a dead human body and other human remains at the same time and in the same alkaline

573.32 hydrolysis vessel. This section does not apply where commingling of human remains

573.33 during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental

573.34 and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is

573.35 not a violation of this subdivision.

574.1 Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis**
574.2 **vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be
574.3 made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed
574.4 remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be
574.5 made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed
574.6 human remains and dispose of these materials in a lawful manner, by the alkaline
574.7 hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate
574.8 container to be transported to the processing area.

574.9 Subd. 22. **Drying device or mechanical processor procedures; commingling of**
574.10 **hydrolyzed remains prohibited.** Except with the express written permission of the
574.11 person with the legal right to control the final disposition or otherwise provided by
574.12 law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed
574.13 human remains of more than one body at a time in the same drying device or mechanical
574.14 processor, or introduce the hydrolyzed human remains of a second body into a drying
574.15 device or mechanical processor until processing of any preceding hydrolyzed human
574.16 remains has been terminated and reasonable efforts have been employed to remove all
574.17 fragments of the preceding hydrolyzed remains. The fact that there is incidental and
574.18 unavoidable residue in the drying device, the mechanical processor, or any container used
574.19 in a prior alkaline hydrolysis process, is not a violation of this provision.

574.20 Subd. 23. **Alkaline hydrolysis procedures; processing hydrolyzed remains.** The
574.21 hydrolyzed human remains shall be dried and then reduced by a motorized mechanical
574.22 device to a granulated appearance appropriate for final disposition and placed in an
574.23 alkaline hydrolysis remains container along with the appropriate identifying disk, tab,
574.24 or permanent label. Processing must take place within the licensed alkaline hydrolysis
574.25 facility. Dental gold, silver or amalgam, jewelry, or mementos, to the extent that they
574.26 can be identified, may be removed prior to processing the hydrolyzed remains, only by
574.27 staff licensed or registered by the commissioner of health; however, any dental gold and
574.28 silver, jewelry, or mementos that are removed shall be returned to the hydrolyzed remains
574.29 container unless otherwise directed by the person or persons having the right to control the
574.30 final disposition. Every person who removes or possesses dental gold or silver, jewelry,
574.31 or mementos from any hydrolyzed remains without specific written permission of the
574.32 person or persons having the right to control those remains is guilty of a misdemeanor.
574.33 The fact that residue and any unavoidable dental gold or dental silver, or other precious
574.34 metals remain in the alkaline hydrolysis vessel or other equipment or any container used
574.35 in a prior hydrolysis is not a violation of this section.

575.1 Subd. 24. **Alkaline hydrolysis procedures; container of insufficient capacity.**

575.2 If a hydrolyzed remains container is of insufficient capacity to accommodate all
575.3 hydrolyzed remains of a given dead human body, subject to directives provided in the
575.4 written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess
575.5 hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the
575.6 second container, in a manner so as not to be easily detached through incidental contact, to
575.7 the primary alkaline hydrolysis remains container. The secondary container shall contain a
575.8 duplicate of the identification disk, tab, or permanent label that was placed in the primary
575.9 container and all paperwork regarding the given body shall include a notation that the
575.10 hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature
575.11 hydrolyzed remains containers are not subject to the requirements of this subdivision.

575.12 Subd. 25. **Disposition procedures; commingling of hydrolyzed remains**

575.13 **prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in
575.14 a location where the hydrolyzed remains are commingled with those of another person
575.15 without the express written permission of the person with the legal right to control
575.16 disposition or as otherwise provided by law. This subdivision does not apply to the
575.17 scattering or burial of hydrolyzed remains at sea or in a body of water from individual
575.18 containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to
575.19 the disposal in a dedicated cemetery of accumulated residue removed from an alkaline
575.20 hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members
575.21 of the same family in a common container designed for the hydrolyzed remains of more
575.22 than one body, or to the inurnment in a container or interment in a space that has been
575.23 previously designated, at the time of sale or purchase, as being intended for the inurnment
575.24 or interment of the hydrolyzed remains of more than one person.

575.25 Subd. 26. **Alkaline hydrolysis procedures; disposition of accumulated residue.**

575.26 Every alkaline hydrolysis facility shall provide for the removal and disposition in a
575.27 dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel,
575.28 drying device, mechanical processor, container, or other equipment used in alkaline
575.29 hydrolysis. Disposition of accumulated residue shall be according to the regulations of the
575.30 dedicated cemetery and any applicable local ordinances.

575.31 Subd. 27. **Alkaline hydrolysis procedures; release of hydrolyzed remains.**

575.32 Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be
575.33 released according to the instructions given on the written authorization to hydrolyze. If
575.34 the hydrolyzed remains are to be shipped, they must be securely packaged and transported
575.35 by a method which has an internal tracing system available and which provides for a
575.36 receipt signed by the person accepting delivery. Where there is a dispute over release

576.1 or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit
576.2 the hydrolyzed remains with a court of competent jurisdiction pending resolution of the
576.3 dispute or retain the hydrolyzed remains until the person with the legal right to control
576.4 disposition presents satisfactory indication that the dispute is resolved.

576.5 Subd. 28. **Unclaimed hydrolyzed remains.** If, after 30 calendar days following
576.6 the inurnment, the hydrolyzed remains are not claimed or disposed of according to the
576.7 written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment
576.8 may give written notice, by certified mail, to the person with the legal right to control
576.9 the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and
576.10 requesting further release directions. Should the hydrolyzed remains be unclaimed 120
576.11 calendar days following the mailing of the written notification, the alkaline hydrolysis
576.12 facility or funeral establishment may dispose of the hydrolyzed remains in any lawful
576.13 manner deemed appropriate.

576.14 Subd. 29. **Required records.** Every alkaline hydrolysis facility shall create and
576.15 maintain on its premises or other business location in Minnesota an accurate record of
576.16 every hydrolyzation provided. The record shall include all of the following information
576.17 for each hydrolyzation:

576.18 (1) the name of the person or funeral establishment delivering the body for alkaline
576.19 hydrolysis;

576.20 (2) the name of the deceased and the identification number assigned to the body;

576.21 (3) the date of acceptance of delivery;

576.22 (4) the names of the alkaline hydrolysis vessel, drying device, and mechanical
576.23 processor operator;

576.24 (5) the time and date that the body was placed in and removed from the alkaline
576.25 hydrolysis vessel;

576.26 (6) the time and date that processing and inurnment of the hydrolyzed remains
576.27 was completed;

576.28 (7) the time, date, and manner of release of the hydrolyzed remains;

576.29 (8) the name and address of the person who signed the authorization to hydrolyze;

576.30 (9) all supporting documentation, including any transit or disposition permits, a
576.31 photocopy of the death record, and the authorization to hydrolyze; and

576.32 (10) the type of alkaline hydrolysis container.

576.33 Subd. 30. **Retention of records.** Records required under subdivision 29 shall be
576.34 maintained for a period of three calendar years after the release of the hydrolyzed remains.
576.35 Following this period and subject to any other laws requiring retention of records, the
576.36 alkaline hydrolysis facility may then place the records in storage or reduce them to

577.1 microfilm, microfiche, laser disc, or any other method that can produce an accurate
577.2 reproduction of the original record, for retention for a period of ten calendar years from
577.3 the date of release of the hydrolyzed remains. At the end of this period and subject to any
577.4 other laws requiring retention of records, the alkaline hydrolysis facility may destroy
577.5 the records by shredding, incineration, or any other manner that protects the privacy of
577.6 the individuals identified.

577.7 Sec. 96. Minnesota Statutes 2012, section 149A.96, subdivision 9, is amended to read:

577.8 Subd. 9. **Hydrolyzed and cremated remains.** Subject to section 149A.95,
577.9 subdivision 16, inurnment of the hydrolyzed or cremated remains and release to an
577.10 appropriate party is considered final disposition and no further permits or authorizations
577.11 are required for disinterment, transportation, or placement of the hydrolyzed or cremated
577.12 remains.

577.13 Sec. 97. Minnesota Statutes 2012, section 257.75, subdivision 7, is amended to read:

577.14 Subd. 7. **Hospital and Department of Health; recognition form.** Hospitals that
577.15 provide obstetric services and the state registrar of vital statistics shall distribute the
577.16 educational materials and recognition of parentage forms prepared by the commissioner of
577.17 human services to new parents, shall assist parents in understanding the recognition of
577.18 parentage form, including following the provisions for notice under subdivision 5, shall
577.19 provide notary services for parents who complete the recognition of parentage form, and
577.20 shall timely file the completed recognition of parentage form with the Office of ~~the State~~
577.21 ~~Registrar of Vital Statistics Records~~ unless otherwise instructed by the Office of ~~the State~~
577.22 ~~Registrar of Vital Statistics Records~~. ~~On and after January 1, 1994, hospitals may not~~
577.23 ~~distribute the declaration of parentage forms.~~

577.24 Sec. 98. Minnesota Statutes 2012, section 260C.635, subdivision 1, is amended to read:

577.25 Subdivision 1. **Legal effect.** (a) Upon adoption, the adopted child becomes the legal
577.26 child of the adopting parent and the adopting parent becomes the legal parent of the child
577.27 with all the rights and duties between them of a birth parent and child.

577.28 (b) The child shall inherit from the adoptive parent and the adoptive parent's
577.29 relatives the same as though the child were the birth child of the parent, and in case of the
577.30 child's death intestate, the adoptive parent and the adoptive parent's relatives shall inherit
577.31 the child's estate as if the child had been the adoptive parent's birth child.

577.32 (c) After a decree of adoption is entered, the birth parents or previous legal parents
577.33 of the child shall be relieved of all parental responsibilities for the child except child

578.1 support that has accrued to the date of the order for guardianship to the commissioner
578.2 which continues to be due and owing. The child's birth or previous legal parent shall not
578.3 exercise or have any rights over the adopted child or the adopted child's property, person,
578.4 privacy, or reputation.

578.5 (d) The adopted child shall not owe the birth parents or the birth parent's relatives
578.6 any legal duty nor shall the adopted child inherit from the birth parents or kindred unless
578.7 otherwise provided for in a will of the birth parent or kindred.

578.8 (e) Upon adoption, the court shall complete a certificate of adoption form and mail
578.9 the form to the Office of ~~the State Registrar~~ Vital Records at the Minnesota Department
578.10 of Health. Upon receiving the certificate of adoption, the state registrar shall register a
578.11 replacement vital record in the new name of the adopted child as required under section
578.12 144.218.

578.13 Sec. 99. Minnesota Statutes 2012, section 517.001, is amended to read:

578.14 **517.001 DEFINITION.**

578.15 As used in this chapter, "local registrar" ~~has the meaning given in section 144.212,~~
578.16 ~~subdivision 10~~ means an individual designated by the county board of commissioners to
578.17 register marriages.

578.18 Sec. 100. Laws 2011, First Special Session chapter 9, article 2, section 27, is amended
578.19 to read:

578.20 Sec. 27. **MINNESOTA TASK FORCE ON PREMATURITY.**

578.21 Subdivision 1. **Establishment.** The Minnesota Task Force on Prematurity is
578.22 established to evaluate and make recommendations on methods for reducing prematurity
578.23 and improving premature infant health care in the state.

578.24 Subd. 2. **Membership; meetings; staff.** (a) The task force shall be composed of at
578.25 least the following members, who serve at the pleasure of their appointing authority:

578.26 (1) ~~15~~ 11 representatives of the Minnesota Prematurity Coalition including, but not
578.27 limited to, health care providers who treat pregnant women or neonates, organizations
578.28 focused on preterm births, early childhood education and development professionals, and
578.29 families affected by prematurity;

578.30 (2) one representative appointed by the commissioner of human services;

578.31 (3) two representatives appointed by the commissioner of health;

578.32 (4) one representative appointed by the commissioner of education;

578.33 (5) two members of the house of representatives, one appointed by the speaker of
578.34 the house and one appointed by the minority leader; and

579.1 (6) two members of the senate, appointed according to the rules of the senate.

579.2 (b) Members of the task force serve without compensation or payment of expenses.

579.3 (c) The commissioner of health must convene the first meeting of the Minnesota
579.4 Task Force on Prematurity by July 31, 2011. The task force must continue to meet at
579.5 least quarterly. Staffing and technical assistance shall be provided by the Minnesota
579.6 Perinatal Coalition.

579.7 Subd. 3. **Duties.** The task force must report the current state of prematurity in
579.8 Minnesota and develop recommendations on strategies for reducing prematurity and
579.9 improving premature infant health care in the state by ~~considering the following:~~

579.10 (1) promoting adherence to standards of care for premature infants born less than 37
579.11 weeks gestational age, including recommendations to improve utilization of appropriate
579.12 hospital discharge and follow-up care procedures;

579.13 (2) coordination of information among appropriate professional and advocacy
579.14 organizations on measures to improve health care for infants born prematurely;

579.15 (3) identification and centralization of available resources to improve access and
579.16 awareness for caregivers of premature infants; and

579.17 ~~(4) development and dissemination of evidence-based practices through networking~~
579.18 ~~and educational opportunities;~~

579.19 ~~(5) a review of relevant evidence-based research regarding the causes and effects of~~
579.20 ~~premature births in Minnesota;~~

579.21 ~~(6) a review of relevant evidence-based research regarding premature infant health~~
579.22 ~~care, including methods for improving quality of and access to care for premature infants;~~

579.23 ~~(7) (4) a review of the potential improvements in health status related to the use of~~
579.24 ~~health care homes to provide and coordinate pregnancy-related services; and~~

579.25 ~~(8) identification of gaps in public reporting measures and possible effects of these~~
579.26 ~~measures on prematurity rates.~~

579.27 Subd. 4. **Report; expiration.** (a) By ~~November 30, 2011~~ January 15, 2015, the
579.28 task force must submit a final report to the chairs and ranking minority members of
579.29 the legislative policy committees on health and human services on the current state of
579.30 prematurity in Minnesota ~~to the chairs of the legislative policy committees on health and~~
579.31 ~~human services, including any recommendations to reduce premature births and improve~~
579.32 premature infant health in the state.

579.33 (b) By ~~January 15, 2013~~, the task force must report its final recommendations,
579.34 ~~including any draft legislation necessary for implementation, to the chairs of the legislative~~
579.35 ~~policy committees on health and human services.~~

580.1 (e) (b) This task force expires on January 31, ~~2013~~ 2015, or upon submission of the
580.2 final report required in paragraph ~~(b)~~ (a), whichever is earlier.

580.3 Sec. 101. **FUNERAL ESTABLISHMENTS; BRANCH LOCATIONS.**

580.4 The commissioner of health shall review the statutory requirements for preparation
580.5 and embalming rooms and develop legislation with input from stakeholders that provides
580.6 appropriate health and safety protection for funeral home locations where deceased bodies
580.7 are present, but are branch locations associated through a majority ownership of a licensed
580.8 funeral establishment that meets the requirements of Minnesota Statutes, sections 149A.50
580.9 and 149A.92, subdivisions 2 to 10. The review shall include consideration of distance
580.10 between the main location and branch, and other health and safety issues.

580.11 Sec. 102. **HEALTH EQUITY REPORT.**

580.12 By February 1, 2014, the commissioner of health, in consultation with local public
580.13 health, health care, and community partners, must submit a report to the chairs and ranking
580.14 minority members of the committees with jurisdiction over health policy and finance, on a
580.15 plan for advancing health equity in Minnesota. The report must include the following:

580.16 (1) assessment of health disparities that exist in the state and how these disparities
580.17 relate to health equity;

580.18 (2) identification of policies, processes, and systems that contribute to health
580.19 inequity in the state;

580.20 (3) recommendations for changes to policies, processes and systems within the
580.21 Department of Health that would increase the department's leadership in addressing health
580.22 inequities;

580.23 (4) identification of best practices for local public health, health care, and community
580.24 partners to provide culturally responsive services and advance health equity; and

580.25 (5) recommendations for strategies for the use of data to document and monitor
580.26 existing health inequities and to evaluate effectiveness of policies, processes, systems,
580.27 and environmental changes that will advance health equity.

580.28 Sec. 103. **GUARANTEED RENEWABILITY STUDY.**

580.29 The commissioner of commerce, in consultation with the commissioner of health,
580.30 and representatives of health carriers and consumer advocates, shall study guaranteed
580.31 renewability of health plans in the individual market and assess the need for statutory
580.32 provisions related to permitting the discontinuance or modification of health plan
580.33 coverage in the individual market by a health carrier. The commissioner shall submit

581.1 recommendations and draft legislation, if needed, to the chairs and ranking minority
581.2 members of the legislative committees with jurisdiction over health insurance policy
581.3 issues by February 1, 2014.

581.4 Sec. 104. **CAPITAL RESERVES LIMITS STUDY.**

581.5 By February 1, 2014, the commissioner of health, in consultation with the
581.6 commissioners of human services and commerce, shall study methodologies for
581.7 determining appropriate levels for capital reserves of health maintenance organizations
581.8 and requirements for reducing capital reserves to any recommended maximum levels.
581.9 In conducting the study, the commissioner shall consult with health maintenance
581.10 organizations, stakeholders, consumers, and other states' insurance regulators. The
581.11 commissioner shall make recommendations on the need for a level of capital reserves, and
581.12 framework for implementing any recommended levels. The commissioner shall submit
581.13 a report to the chairs and ranking minority members of the legislative committees with
581.14 jurisdiction over health and human services.

581.15 Sec. 105. **STUDY AND RECOMMENDATIONS REGARDING MINNESOTA**
581.16 **COMPREHENSIVE HEALTH ASSOCIATION.**

581.17 By August 15, 2013, the Department of Commerce shall study and report to the
581.18 legislature on reasonable and efficient options for coverage for high-quality, medically
581.19 necessary, evidence-based treatment of autism spectrum disorders up to age 18, including
581.20 whether the Minnesota Comprehensive Health Association could provide coverage
581.21 options through January 1, 2016, under Minnesota Statutes, chapter 62E.

581.22 Sec. 106. **ESSENTIAL HEALTH BENEFITS.**

581.23 By December 31, 2014, the Department of Commerce shall request that the United
581.24 States Department of Human Services include autism services in Minnesota's Essential
581.25 Health Benefits when the next benefit set is selected in 2016. These services should
581.26 include but not be limited to the services listed in Minnesota Statutes, section 62A.3094,
581.27 subdivision 2, paragraph (a).

581.28 Sec. 107. **ATTORNEY GENERAL LEGAL OPINION REQUIRED.**

581.29 Pursuant to the requirements of Minnesota Statutes, section 8.05, and no later than
581.30 October 1, 2013, the attorney general shall give a written legal opinion on whether a
581.31 health plan, as defined by Minnesota Statutes, section 62Q.01, subdivision 3, is required
581.32 to provide coverage of treatment for mental health and mental health-related illnesses,

582.1 including autism spectrum disorders and any other mental health condition as determined
582.2 by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of
582.3 Mental Disorders of the American Psychiatric Association. The attorney general shall
582.4 provide copies of this legal opinion to the commissioners of commerce and human
582.5 services, the board of directors of the Minnesota Insurance Marketplace, and the legislative
582.6 chairs with jurisdiction over commerce and health policy.

582.7 Sec. 108. **REVISOR'S INSTRUCTION.**

582.8 The revisor shall substitute the term "vertical heat exchangers" or "vertical
582.9 heat exchanger" with "bored geothermal heat exchangers" or "bored geothermal heat
582.10 exchanger" wherever it appears in Minnesota Statutes, sections 103I.005, subdivisions
582.11 2 and 12; 103I.101, subdivisions 2 and 5; 103I.105; 103I.205, subdivision 4; 103I.208,
582.12 subdivision 2; 103I.501; 103I.531, subdivision 5; and 103I.641, subdivisions 1, 2, and 3.

582.13 Sec. 109. **REPEALER.**

582.14 (a) Minnesota Statutes 2012, sections 62J.693; 103I.005, subdivision 20; 149A.025;
582.15 149A.20, subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45,
582.16 subdivision 6; 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a;
582.17 149A.53, subdivision 9; and 485.14, are repealed.

582.18 (b) Minnesota Statutes 2012, section 144.123, subdivision 2, is repealed effective
582.19 July 1, 2014.

582.20 **ARTICLE 13**

582.21 **PAYMENT METHODOLOGIES FOR HOME AND** 582.22 **COMMUNITY-BASED SERVICES**

582.23 Section 1. Minnesota Statutes 2012, section 252.41, subdivision 3, is amended to read:

582.24 Subd. 3. **Day training and habilitation services for adults with developmental**
582.25 **disabilities.** "Day training and habilitation services for adults with developmental
582.26 disabilities" means services that:

582.27 (1) include supervision, training, assistance, and supported employment,
582.28 work-related activities, or other community-integrated activities designed and
582.29 implemented in accordance with the individual service and individual habilitation plans
582.30 required under Minnesota Rules, parts 9525.0015 to 9525.0165, to help an adult reach
582.31 and maintain the highest possible level of independence, productivity, and integration
582.32 into the community; and

583.1 (2) are provided ~~under contract with the county where the services are delivered~~
583.2 by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to
583.3 provide day training and habilitation services.

583.4 Day training and habilitation services reimbursable under this section do not include
583.5 special education and related services as defined in the Education of the Individuals with
583.6 Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and
583.7 (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973,
583.8 United States Code, title 29, section 720, as amended.

583.9 **EFFECTIVE DATE.** This section is effective January 1, 2014.

583.10 Sec. 2. Minnesota Statutes 2012, section 252.42, is amended to read:

583.11 **252.42 SERVICE PRINCIPLES.**

583.12 The design and delivery of services eligible for reimbursement ~~under the rates~~
583.13 ~~established in section 252.46~~ should reflect the following principles:

583.14 (1) services must suit a person's chronological age and be provided in the least
583.15 restrictive environment possible, consistent with the needs identified in the person's
583.16 individual service and individual habilitation plans under Minnesota Rules, parts
583.17 9525.0015 to 9525.0165;

583.18 (2) a person with a developmental disability whose individual service and individual
583.19 habilitation plans authorize employment or employment-related activities shall be given
583.20 the opportunity to participate in employment and employment-related activities in which
583.21 nondisabled persons participate;

583.22 (3) a person with a developmental disability participating in work shall be paid
583.23 wages commensurate with the rate for comparable work and productivity except as
583.24 regional centers are governed by section 246.151;

583.25 (4) a person with a developmental disability shall receive services which include
583.26 services offered in settings used by the general public and designed to increase the person's
583.27 active participation in ordinary community activities;

583.28 (5) a person with a developmental disability shall participate in the patterns,
583.29 conditions, and rhythms of everyday living and working that are consistent with the norms
583.30 of the mainstream of society.

583.31 **EFFECTIVE DATE.** This section is effective January 1, 2014.

583.32 Sec. 3. Minnesota Statutes 2012, section 252.43, is amended to read:

583.33 **252.43 COMMISSIONER'S DUTIES.**

584.1 The commissioner shall supervise county boards' provision of day training and
584.2 habilitation services to adults with developmental disabilities. The commissioner shall:
584.3 (1) determine the need for day training and habilitation services under section 252.28;
584.4 (2) ~~approve~~ establish payment rates ~~established by a county under section 252.46,~~
584.5 ~~subdivision 1~~ as provided under section 256B.4914;
584.6 (3) adopt rules for the administration and provision of day training and habilitation
584.7 services under sections ~~252.40~~ 252.41 to 252.46 and sections 245A.01 to 245A.16 and
584.8 252.28, subdivision 2;
584.9 (4) enter into interagency agreements necessary to ensure effective coordination and
584.10 provision of day training and habilitation services;
584.11 (5) monitor and evaluate the costs and effectiveness of day training and habilitation
584.12 services; and
584.13 (6) provide information and technical help to county boards and vendors in their
584.14 administration and provision of day training and habilitation services.

584.15 **EFFECTIVE DATE.** This section is effective January 1, 2014.

584.16 Sec. 4. Minnesota Statutes 2012, section 252.44, is amended to read:

584.17 **252.44 COUNTY BOARD RESPONSIBILITIES.**

584.18 (a) When the need for day training and habilitation services in a county has been
584.19 determined under section 252.28, the board of commissioners for that county shall:

584.20 (1) authorize the delivery of services according to the individual service and
584.21 habilitation plans required as part of the county's provision of case management services
584.22 under Minnesota Rules, parts 9525.0015 to 9525.0165. For calendar years for which
584.23 section 252.46, subdivisions 2 to 10, apply, the county board shall not authorize a change
584.24 in service days from the number of days authorized for the previous calendar year unless
584.25 there is documentation for the change in the individual service plan. An increase in service
584.26 days must also be supported by documentation that the goals and objectives assigned to the
584.27 vendor cannot be met more economically and effectively by other available community
584.28 services and that without the additional days of service the individual service plan could
584.29 not be implemented in a manner consistent with the service principles in section 252.42;

584.30 ~~(2) contract with licensed vendors, as specified in paragraph (b), under sections~~
584.31 ~~256E.12 and 256B.092 and rules adopted under those sections;~~

584.32 ~~(3)~~ (2) ensure that transportation is provided or arranged by the vendor in the most
584.33 efficient and reasonable way possible; and

584.34 ~~(4) set payment rates under section 252.46;~~

585.1 ~~(5) (3) monitor and evaluate the cost and effectiveness of the services; and~~
585.2 ~~(6) reimburse vendors for the provision of authorized services according to the rates,~~
585.3 ~~procedures, and regulations governing reimbursement.~~

585.4 ~~(b) With all vendors except regional centers, the contract must include the approved~~
585.5 ~~payment rates, the projected budget for the contract period, and any actual expenditures~~
585.6 ~~of previous and current contract periods. With all vendors, including regional centers,~~
585.7 ~~the contract must also include the amount, availability, and components of day training~~
585.8 ~~and habilitation services to be provided, the performance standards governing service~~
585.9 ~~provision and evaluation, and the time period in which the contract is effective.~~

585.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

585.11 Sec. 5. Minnesota Statutes 2012, section 252.45, is amended to read:

585.12 **252.45 VENDOR'S DUTIES.**

585.13 ~~A vendor's responsibility~~ vendor enrolled with the commissioner is responsible for
585.14 items under clauses (1), (2), and (3), and extends only to the provision of services that are
585.15 reimbursable under state and federal law. A vendor ~~under contract with a county board to~~
585.16 ~~provide~~ providing day training and habilitation services shall:

585.17 (1) provide the amount and type of services authorized in the individual service plan
585.18 under Minnesota Rules, parts 9525.0015 to 9525.0165;

585.19 (2) design the services to achieve the outcomes assigned to the vendor in the
585.20 individual service plan;

585.21 (3) provide or arrange for transportation of persons receiving services to and from
585.22 service sites;

585.23 (4) enter into agreements with community-based intermediate care facilities for
585.24 persons with developmental disabilities to ensure compliance with applicable federal
585.25 regulations; and

585.26 (5) comply with state and federal law.

585.27 **EFFECTIVE DATE.** This section is effective January 1, 2014.

585.28 Sec. 6. Minnesota Statutes 2012, section 252.46, subdivision 1a, is amended to read:

585.29 Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish
585.30 a statewide rate-setting methodology for all day training and habilitation services as
585.31 provided under section 256B.4914. The rate-setting methodology must abide by the
585.32 principles of transparency and equitability across the state. The methodology must involve

586.1 a uniform process of structuring rates for each service and must promote quality and
586.2 participant choice.

586.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

586.4 Sec. 7. Minnesota Statutes 2012, section 256B.4912, subdivision 2, is amended to read:

586.5 Subd. 2. **Payment methodologies.** (a) The commissioner shall establish, as defined
586.6 under section 256B.4914, statewide payment methodologies that meet federal waiver
586.7 requirements for home and community-based waiver services for individuals with
586.8 disabilities. The payment methodologies must abide by the principles of transparency
586.9 and equitability across the state. The methodologies must involve a uniform process of
586.10 structuring rates for each service and must promote quality and participant choice.

586.11 (b) As of January 1, 2012, counties shall not implement changes to established
586.12 processes for rate-setting methodologies for individuals using components of or data
586.13 from research rates.

586.14 Sec. 8. Minnesota Statutes 2012, section 256B.4912, subdivision 3, is amended to read:

586.15 Subd. 3. **Payment requirements.** The payment methodologies established under
586.16 this section shall accommodate:

- 586.17 (1) supervision costs;
586.18 (2) ~~staffing patterns~~ staff compensation;
586.19 (3) staffing and supervisory patterns;
586.20 ~~(3)~~ (4) program-related expenses;
586.21 ~~(4)~~ (5) general and administrative expenses; and
586.22 ~~(5)~~ (6) consideration of recipient intensity.

586.23 Sec. 9. Minnesota Statutes 2012, section 256B.4913, is amended by adding a
586.24 subdivision to read:

586.25 Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision,
586.26 "implementation period" shall mean the period beginning January 1, 2014, and ending
586.27 on the last day of the month in which the rate management system is populated with the
586.28 data necessary to calculate rates for substantially all individuals receiving home and
586.29 community-based services.

586.30 (b) For purposes of this subdivision, the banding value for all service recipients
586.31 shall mean the individual reimbursement rate for a recipient in effect on December 1,
586.32 2013, except that:

587.1 (1)(i) for day training and habilitation pilot program service recipients, the banding
587.2 value shall be the authorized rate for the provider in the county of service effective
587.3 December 1, 2013, if the recipient: was not authorized to receive these waiver services
587.4 prior to January 1, 2014; added a new service or services on or after January 1, 2014; or
587.5 changed providers on or after January 1, 2014; and

587.6 (ii) for all other unit or day service recipients, the banding value shall be the
587.7 weighted average authorized rate for each provider number in the county of service
587.8 effective December 1, 2013, if the recipient: was not authorized to receive these waiver
587.9 services prior to January 1, 2014; added a new service or services on or after January 1,
587.10 2014; or changed providers on or after January 1, 2014; and

587.11 (2) for residential service recipients who change providers on or after January 1,
587.12 2014, the banding value shall be set by each lead agency within their county aggregate
587.13 budget using their respective methodology for residential services effective December 1,
587.14 2013, for determining the provider rate for a similarly situated recipient being served by
587.15 that provider.

587.16 (c) The commissioner shall adjust individual reimbursement rates determined under
587.17 this section so that the unit rate is no higher or lower than:

587.18 (1) 0.5 percent from the banding value for the implementation period;

587.19 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period
587.20 immediately following the time period of clause (1);

587.21 (3) 1.0 percent from the rate in effect in clause (2), for the 12-month period
587.22 immediately following the time period of clause (2);

587.23 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period
587.24 immediately following the time period of clause (3); and

587.25 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period
587.26 immediately following the time period of clause (4).

587.27 (d) This subdivision shall not apply to rates for recipients served by providers new
587.28 to a given county after January 1, 2014.

587.29 Sec. 10. Minnesota Statutes 2012, section 256B.4913, subdivision 5, is amended to read:

587.30 Subd. 5. **Stakeholder consultation.** The commissioner shall continue consultation
587.31 on regular intervals with the existing stakeholder group established as part of the
587.32 rate-setting methodology process and others, to gather input, concerns, and data, and
587.33 exchange ideas for the legislative proposals for to assist in the full implementation of
587.34 the new rate payment system and to make pertinent information available to the public
587.35 through the department's Web site.

588.1 Sec. 11. Minnesota Statutes 2012, section 256B.4913, subdivision 6, is amended to read:

588.2 Subd. 6. **Implementation.** (a) The commissioner ~~may~~ shall implement changes
588.3 ~~no sooner than~~ on January 1, 2014, to payment rates for individuals receiving home and
588.4 community-based waived services after the enactment of legislation that establishes
588.5 specific payment methodology frameworks, processes for rate calculations, and specific
588.6 values to populate the ~~payment methodology frameworks~~ disability waiver rates system.

588.7 (b) On January 1, 2014, all new service authorizations must use the disability waiver
588.8 rates system. Beginning January 1, 2014, all renewing individual service plans must use the
588.9 disability waiver rates system as reassessment and reauthorization occurs. By December
588.10 31, 2014, data for all recipients must be entered into the disability waiver rates system.

588.11 Sec. 12. **[256B.4914] HOME AND COMMUNITY-BASED SERVICES**
588.12 **WAIVERS; RATE SETTING.**

588.13 Subdivision 1. **Application.** The payment methodologies in this section apply to
588.14 home and community-based services waivers under sections 256B.092 and 256B.49. This
588.15 section does not change existing waiver policies and procedures.

588.16 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
588.17 meanings given them, unless the context clearly indicates otherwise.

588.18 (b) "Commissioner" means the commissioner of human services.

588.19 (c) "Component value" means underlying factors that are part of the cost of providing
588.20 services that are built into the waiver rates methodology to calculate service rates.

588.21 (d) "Customized living tool" means a methodology for setting service rates that
588.22 delineates and documents the amount of each component service included in a recipient's
588.23 customized living service plan.

588.24 (e) "Disability waiver rates system" means a statewide system that establishes rates
588.25 that are based on uniform processes and captures the individualized nature of waiver
588.26 services and recipient needs.

588.27 (f) "Lead agency" means a county, partnership of counties, or tribal agency charged
588.28 with administering waived services under sections 256B.092 and 256B.49.

588.29 (g) "Median" means the amount that divides distribution into two equal groups,
588.30 one-half above the median and one-half below the median.

588.31 (h) "Payment or rate" means reimbursement to an eligible provider for services
588.32 provided to a qualified individual based on an approved service authorization.

588.33 (i) "Rates management system" means a Web-based software application that uses
588.34 a framework and component values, as determined by the commissioner, to establish
588.35 service rates.

589.1 (j) "Recipient" means a person receiving home and community-based services
589.2 funded under any of the disability waivers.

589.3 Subd. 3. **Applicable services.** Applicable services are those authorized under
589.4 the state's home and community-based services waivers under sections 256B.092 and
589.5 256B.49, including the following, as defined in the federally approved home and
589.6 community-based services plan:

- 589.7 (1) 24 hour customized living;
- 589.8 (2) adult day care;
- 589.9 (3) adult day care bath;
- 589.10 (4) behavioral programming;
- 589.11 (5) companion services;
- 589.12 (6) customized living;
- 589.13 (7) day training and habilitation;
- 589.14 (8) housing access coordination;
- 589.15 (9) independent living skills;
- 589.16 (10) in-home family support;
- 589.17 (11) night supervision;
- 589.18 (12) personal support;
- 589.19 (13) prevocational services;
- 589.20 (14) residential care services;
- 589.21 (15) residential support services;
- 589.22 (16) respite services;
- 589.23 (17) structured day services;
- 589.24 (18) supported employment services;
- 589.25 (19) supported living services;
- 589.26 (20) transportation services; and
- 589.27 (21) other services as approved by the federal government in the state home and
589.28 community-based services plan.

589.29 Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home
589.30 and community-based waived services, including rate exceptions under subdivision 12,
589.31 are set by the rates management system.

589.32 (b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a
589.33 manner prescribed by the commissioner.

589.34 (c) Data and information in the rates management system may be used to calculate
589.35 an individual's rate.

590.1 (d) Service providers, with information from the community support plan and
590.2 oversight by lead agencies, shall provide values and information needed to calculate an
590.3 individual's rate into the rates management system. These values and information include:

590.4 (1) shared staffing hours;

590.5 (2) individual staffing hours;

590.6 (3) direct RN hours;

590.7 (4) direct LPN hours;

590.8 (5) staffing ratios;

590.9 (6) information to document variable levels of service qualification for variable
590.10 levels of reimbursement in each framework;

590.11 (7) shared or individualized arrangements for unit-based services, including the
590.12 staffing ratio;

590.13 (8) number of trips and miles for transportation services; and

590.14 (9) service hours provided through monitoring technology.

590.15 (e) Updates to individual data shall include:

590.16 (1) data for each individual that is updated annually when renewing service plans; and

590.17 (2) requests by individuals or lead agencies to update a rate whenever there is a
590.18 change in an individual's service needs, with accompanying documentation.

590.19 (f) Lead agencies shall review and approve values to calculate the final payment rate
590.20 for each individual. Lead agencies must notify the individual and the service provider
590.21 of the final agreed-upon values and rate. If a value used was mistakenly or erroneously
590.22 entered and used to calculate a rate, a provider may petition lead agencies to correct it.
590.23 Lead agencies must respond to these requests.

590.24 Subd. 5. **Base wage index and standard component values.** (a) The base wage
590.25 index is established to determine staffing costs associated with providing services to
590.26 individuals receiving home and community-based services. For purposes of developing
590.27 and calculating the proposed base wage, Minnesota-specific wages taken from job
590.28 descriptions and standard occupational classification (SOC) codes from the Bureau of
590.29 Labor Statistics as defined in the most recent edition of the Occupational Handbook shall
590.30 be used. The base wage index shall be calculated as follows:

590.31 (1) for residential direct care staff, the sum of:

590.32 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and
590.33 home health aide (SOC code 39-9021); 30 percent of the median wage for nursing aide
590.34 (SOC code 31-1012); and 20 percent of the median wage for social and human services
590.35 aide (SOC code 21-1093); and

591.1 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
591.2 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
591.3 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
591.4 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
591.5 percent of the median wage for social and human services aide (SOC code 21-1093);
591.6 (2) for day services, 20 percent of the median wage for nursing aide (SOC code
591.7 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
591.8 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);
591.9 (3) for residential asleep-overnight staff, the wage will be \$7.66 per hour, except in
591.10 a family foster care setting, the wage is \$2.80 per hour;
591.11 (4) for behavior program analyst staff, 100 percent of the median wage for mental
591.12 health counselors (SOC code 21-1014);
591.13 (5) for behavior program professional staff, 100 percent of the median wage for
591.14 clinical counseling and school psychologist (SOC code 19-3031);
591.15 (6) for behavior program specialist staff, 100 percent of the median wage for
591.16 psychiatric technicians (SOC code 29-2053);
591.17 (7) for supportive living services staff, 20 percent of the median wage for nursing
591.18 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
591.19 code 29-2053); and 60 percent of the median wage for social and human services aide
591.20 (SOC code 21-1093);
591.21 (8) for housing access coordination staff, 50 percent of the median wage for
591.22 community and social services specialist (SOC code 21-1099); and 50 percent of the
591.23 median wage for social and human services aide (SOC code 21-1093);
591.24 (9) for in-home family support staff, 20 percent of the median wage for nursing
591.25 aide (SOC code 31-1012); 30 percent of the median wage for community social service
591.26 specialist (SOC code 21-1099); 40 percent of the median wage for social and human
591.27 services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
591.28 technician (SOC code 29-2053);
591.29 (10) for independent living skills staff, 40 percent of the median wage for community
591.30 social service specialist (SOC code 21-1099); 50 percent of the median wage for social
591.31 and human services aide (SOC code 21-1093); and ten percent of the median wage for
591.32 psychiatric technician (SOC code 29-2053);
591.33 (11) for supported employment staff, 20 percent of the median wage for nursing aide
591.34 (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
591.35 code 29-2053); and 60 percent of the median wage for social and human services aide
591.36 (SOC code 21-1093);

592.1 (12) for adult companion staff, 50 percent of the median wage for personal and home
592.2 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
592.3 orderlies, and attendants (SOC code 31-1012);

592.4 (13) for night supervision staff, 20 percent of the median wage for home health aide
592.5 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
592.6 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
592.7 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
592.8 percent of the median wage for social and human services aide (SOC code 21-1093);

592.9 (14) for respite staff, 50 percent of the median wage for personal and home care aide
592.10 (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and
592.11 attendants (SOC code 31-1012);

592.12 (15) for personal support staff, 50 percent of the median wage for personal and home
592.13 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
592.14 orderlies, and attendants (SOC code 31-1012);

592.15 (16) for supervisory staff, the basic wage is \$17.43 per hour with exception of the
592.16 supervisor of behavior analyst and behavior specialists, which shall be \$30.75 per hour;

592.17 (17) for RN, the basic wage is \$30.82 per hour; and

592.18 (18) for LPN, the basic wage is \$18.64 per hour.

592.19 (b) Component values for residential support services are:

592.20 (1) supervisory span of control ratio: 11 percent;

592.21 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

592.22 (3) employee-related cost ratio: 23.6 percent;

592.23 (4) general administrative support ratio: 13.25 percent;

592.24 (5) program-related expense ratio: 1.3 percent; and

592.25 (6) absence and utilization factor ratio: 3.9 percent.

592.26 (c) Component values for family foster care are:

592.27 (1) supervisory span of control ratio: 11 percent;

592.28 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

592.29 (3) employee-related cost ratio: 23.6 percent;

592.30 (4) general administrative support ratio: 3.3 percent;

592.31 (5) program-related expense ratio: 1.3 percent; and

592.32 (6) absence factor: 1.7 percent.

592.33 (d) Component values for day services for all services are:

592.34 (1) supervisory span of control ratio: 11 percent;

592.35 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

592.36 (3) employee-related cost ratio: 23.6 percent;

- 593.1 (4) program plan support ratio: 5.6 percent;
593.2 (5) client programming and support ratio: ten percent;
593.3 (6) general administrative support ratio: 13.25 percent;
593.4 (7) program-related expense ratio: 1.8 percent; and
593.5 (8) absence and utilization factor ratio: 3.9 percent.
593.6 (e) Component values for unit-based services with programming are:
593.7 (1) supervisory span of control ratio: 11 percent;
593.8 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
593.9 (3) employee-related cost ratio: 23.6 percent;
593.10 (4) program plan supports ratio: 3.1 percent;
593.11 (5) client programming and supports ratio: 8.6 percent;
593.12 (6) general administrative support ratio: 13.25 percent;
593.13 (7) program-related expense ratio: 6.1 percent; and
593.14 (8) absence and utilization factor ratio: 3.9 percent.
593.15 (f) Component values for unit-based services without programming except respite
593.16 are:
593.17 (1) supervisory span of control ratio: 11 percent;
593.18 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
593.19 (3) employee-related cost ratio: 23.6 percent;
593.20 (4) program plan support ratio: 3.1 percent;
593.21 (5) client programming and support ratio: 8.6 percent;
593.22 (6) general administrative support ratio: 13.25 percent;
593.23 (7) program-related expense ratio: 6.1 percent; and
593.24 (8) absence and utilization factor ratio: 3.9 percent.
593.25 (g) Component values for unit-based services without programming for respite are:
593.26 (1) supervisory span of control ratio: 11 percent;
593.27 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
593.28 (3) employee-related cost ratio: 23.6 percent;
593.29 (4) general administrative support ratio: 13.25 percent;
593.30 (5) program-related expense ratio: 6.1 percent; and
593.31 (6) absence and utilization factor ratio: 3.9 percent.
593.32 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph
593.33 (b) based on the wage data by standard occupational code (SOC) from the Bureau of
593.34 Labor Statistics available on December 31, 2016. The commissioner shall publish these
593.35 updated values and load them into the rate management system. This adjustment occurs

594.1 every five years. For adjustments in 2021 and beyond, the commissioner shall use the data
594.2 available on December 31 of the calendar year five years prior.

594.3 (i) On July 1, 2017, the commissioner shall update the framework components in
594.4 paragraph (c) for changes in the Consumer Price Index. The commissioner will adjust
594.5 these values higher or lower by the percentage change in the Consumer Price Index-All
594.6 Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The
594.7 commissioner shall publish these updated values and load them into the rate management
594.8 system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the
594.9 commissioner shall use the data available on January 1 of the calendar year four years
594.10 prior and January 1 of the current calendar year.

594.11 Subd. 6. **Payments for residential support services.** (a) Payments for residential
594.12 support services, as defined in sections 256B.092, subdivision 11, and 256B.49,
594.13 subdivision 22, must be calculated as follows:

594.14 (1) determine the number of shared and individual direct staff hours to meet a
594.15 recipient's needs provided on-site or through monitoring technology;

594.16 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
594.17 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
594.18 5. This is defined as the direct-care rate;

594.19 (3) for a recipient requiring customization for deaf and hard-of-hearing language
594.20 accessibility under subdivision 12, add the customization rate provided in subdivision 12
594.21 to the result of clause (2). This is defined as the customized direct-care rate;

594.22 (4) multiply the number of shared and individual direct staff hours provided on-site
594.23 or through monitoring technology and direct nursing hours by the appropriate staff wages
594.24 in subdivision 5, paragraph (a), or the customized direct-care rate;

594.25 (5) multiply the number of shared and individual direct staff hours provided
594.26 on-site or through monitoring technology and direct nursing hours by the product of
594.27 the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the
594.28 appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

594.29 (6) combine the results of clauses (4) and (5), excluding any shared and individual
594.30 direct staff hours provided through monitoring technology, and multiply the result by one
594.31 plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph
594.32 (b), clause (2). This is defined as the direct staffing cost;

594.33 (7) for employee-related expenses, multiply the direct staffing cost, excluding any
594.34 shared and individual direct staff hours provided through monitoring technology, by one
594.35 plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

594.36 (8) for client programming and supports, the commissioner shall add \$2,179; and

595.1 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
595.2 customized for adapted transport, per year.

595.3 (b) The total rate shall be calculated using the following steps:

595.4 (1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any
595.5 shared and individual direct staff hours provided through monitoring technology that
595.6 was excluded in clause (7);

595.7 (2) sum the standard general and administrative rate, the program-related expense
595.8 ratio, and the absence and utilization ratio;

595.9 (3) divide the result of clause (1) by one minus the result of clause (2). This is
595.10 the total payment amount; and

595.11 (4) adjust the result of clause (3) by a factor to be determined by the commissioner
595.12 to adjust for regional differences in the cost of providing services.

595.13 (c) The payment methodology for customized living, 24-hour customized living, and
595.14 residential care services shall be the customized living tool. Revisions to the customized
595.15 living tool shall be made to reflect the services and activities unique to disability-related
595.16 recipient needs.

595.17 (d) The commissioner shall establish a Monitoring Technology Review Panel to
595.18 annually review and approve the plans, safeguards, and rates that include residential
595.19 direct care provided remotely through monitoring technology. Lead agencies shall submit
595.20 individual service plans that include supervision using monitoring technology to the
595.21 Monitoring Technology Review Panel for approval. Individual service plans that include
595.22 supervision using monitoring technology as of December 31, 2013, shall be submitted to
595.23 the Monitoring Technology Review Panel, but the plans are not subject to approval.

595.24 Subd. 7. **Payments for day programs.** Payments for services with day programs
595.25 including adult day care, day treatment and habilitation, prevocational services, and
595.26 structured day services must be calculated as follows:

595.27 (1) determine the number of units of service to meet a recipient's needs;

595.28 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
595.29 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

595.30 (3) for a recipient requiring customization for deaf and hard-of-hearing language
595.31 accessibility under subdivision 12, add the customization rate provided in subdivision 12
595.32 to the result of clause (2). This is defined as the customized direct-care rate;

595.33 (4) multiply the number of day program direct staff hours and direct nursing hours
595.34 by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care
595.35 rate;

- 596.1 (5) multiply the number of day direct staff hours by the product of the supervision
596.2 span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate
596.3 supervision wage in subdivision 5, paragraph (a), clause (16);
- 596.4 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
596.5 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d),
596.6 clause (2). This is defined as the direct staffing rate;
- 596.7 (7) for program plan support, multiply the result of clause (6) by one plus the
596.8 program plan support ratio in subdivision 5, paragraph (d), clause (4);
- 596.9 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
596.10 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);
- 596.11 (9) for client programming and supports, multiply the result of clause (8) by one plus
596.12 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);
- 596.13 (10) for program facility costs, add \$19.30 per week with consideration of staffing
596.14 ratios to meet individual needs;
- 596.15 (11) for adult day bath services, add \$7.01 per 15 minute unit;
- 596.16 (12) this is the subtotal rate;
- 596.17 (13) sum the standard general and administrative rate, the program-related expense
596.18 ratio, and the absence and utilization factor ratio;
- 596.19 (14) divide the result of clause (12) by one minus the result of clause (13). This is
596.20 the total payment amount;
- 596.21 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
596.22 to adjust for regional differences in the cost of providing services;
- 596.23 (16) for transportation provided as part of day training and habilitation for an
596.24 individual who does not require a lift, add:
- 596.25 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle
596.26 without a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared
596.27 ride in a vehicle with a lift;
- 596.28 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle
596.29 without a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared
596.30 ride in a vehicle with a lift;
- 596.31 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle
596.32 without a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared
596.33 ride in a vehicle with a lift; or
- 596.34 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a
596.35 lift, \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a
596.36 vehicle with a lift;

597.1 (17) for transportation provide as part of day training and habilitation for an
597.2 individual who does require a lift, add:

597.3 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with
597.4 a lift, and \$15.05 for a shared ride in a vehicle with a lift;

597.5 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
597.6 lift, and \$28.16 for a shared ride in a vehicle with a lift;

597.7 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with
597.8 a lift, and \$58.76 for a shared ride in a vehicle with a lift; or

597.9 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a
597.10 lift, and \$80.93 for a shared ride in a vehicle with a lift.

597.11 Subd. 8. **Payments for unit-based services with programming.** Payments for
597.12 unit-based with program services, including behavior programming, housing access
597.13 coordination, in-home family support, independent living skills training, hourly supported
597.14 living services, and supported employment provided to an individual outside of any day or
597.15 residential service plan must be calculated as follows, unless the services are authorized
597.16 separately under subdivision 6 or 7:

597.17 (1) determine the number of units of service to meet a recipient's needs;

597.18 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
597.19 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

597.20 (3) for a recipient requiring customization for deaf and hard-of-hearing language
597.21 accessibility under subdivision 12, add the customization rate provided in subdivision 12
597.22 to the result of clause (2). This is defined as the customized direct-care rate;

597.23 (4) multiply the number of direct staff hours by the appropriate staff wage in
597.24 subdivision 5, paragraph (a), or the customized direct care rate;

597.25 (5) multiply the number of direct staff hours by the product of the supervision span
597.26 of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
597.27 wage in subdivision 5, paragraph (a), clause (16);

597.28 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
597.29 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e),
597.30 clause (2). This is defined as the direct staffing rate;

597.31 (7) for program plan support, multiply the result of clause (6) by one plus the
597.32 program plan supports ratio in subdivision 5, paragraph (e), clause (4);

597.33 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
597.34 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

597.35 (9) for client programming and supports, multiply the result of clause (8) by one plus
597.36 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

598.1 (10) this is the subtotal rate;

598.2 (11) sum the standard general and administrative rate, the program-related expense
598.3 ratio, and the absence and utilization factor ratio;

598.4 (12) divide the result of clause (10) by one minus the result of clause (11). This is
598.5 the total payment amount;

598.6 (13) for supported employment provided in a shared manner, divide the total
598.7 payment amount in clause (12) by the number of service recipients, not to exceed three.

598.8 For independent living skills training provided in a shared manner, divide the total
598.9 payment amount in clause (12) by the number of service recipients, not to exceed two; and

598.10 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
598.11 to adjust for regional differences in the cost of providing services.

598.12 Subd. 9. **Payments for unit-based services without programming.** Payments
598.13 for unit-based without program services, including night supervision, personal support,
598.14 respite, and companion care provided to an individual outside of any day or residential
598.15 service plan must be calculated as follows unless the services are authorized separately
598.16 under subdivision 6 or 7:

598.17 (1) for all services except respite, determine the number of units of service to meet
598.18 a recipient's needs;

598.19 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
598.20 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

598.21 (3) for a recipient requiring customization for deaf and hard-of-hearing language
598.22 accessibility under subdivision 12, add the customization rate provided in subdivision 12
598.23 to the result of clause (2). This is defined as the customized direct care rate;

598.24 (4) multiply the number of direct staff hours by the appropriate staff wage in
598.25 subdivision 5 or the customized direct care rate;

598.26 (5) multiply the number of direct staff hours by the product of the supervision span
598.27 of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
598.28 wage in subdivision 5, paragraph (a), clause (16);

598.29 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
598.30 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f),
598.31 clause (2). This is defined as the direct staffing rate;

598.32 (7) for program plan support, multiply the result of clause (6) by one plus the
598.33 program plan support ratio in subdivision 5, paragraph (f), clause (4);

598.34 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
598.35 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

599.1 (9) for client programming and supports, multiply the result of clause (8) by one plus
599.2 the client programming and support ratio in subdivision 5, paragraph (f), clause (5);
599.3 (10) this is the subtotal rate;
599.4 (11) sum the standard general and administrative rate, the program-related expense
599.5 ratio, and the absence and utilization factor ratio;
599.6 (12) divide the result of clause (10) by one minus the result of clause (11). This is
599.7 the total payment amount;
599.8 (13) for respite services, determine the number of daily units of service to meet an
599.9 individual's needs;
599.10 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
599.11 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
599.12 (15) for a recipient requiring deaf and hard-of-hearing customization under
599.13 subdivision 12, add the customization rate provided in subdivision 12 to the result of
599.14 clause (14). This is defined as the customized direct care rate;
599.15 (16) multiply the number of direct staff hours by the appropriate staff wage in
599.16 subdivision 5, paragraph (a);
599.17 (17) multiply the number of direct staff hours by the product of the supervisory span
599.18 of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
599.19 wage in subdivision 5, paragraph (a), clause (16);
599.20 (18) combine the results of clauses (16) and (17), and multiply the result by one plus
599.21 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g),
599.22 clause (2). This is defined as the direct staffing rate;
599.23 (19) for employee-related expenses, multiply the result of clause (18) by one plus
599.24 the employee-related cost ratio in subdivision 5, paragraph (g), clause (3).
599.25 (20) this is the subtotal rate;
599.26 (21) sum the standard general and administrative rate, the program-related expense
599.27 ratio, and the absence and utilization factor ratio;
599.28 (22) divide the result of clause (20) by one minus the result of clause (21). This is
599.29 the total payment amount; and
599.30 (23) adjust the result of clauses (12) and (22) by a factor to be determined by the
599.31 commissioner to adjust for regional differences in the cost of providing services.
599.32 **Subd. 10. Updating payment values and additional information.** (a) From
599.33 January 1, 2014, through December 31, 2017, the commissioner shall develop and
599.34 implement uniform procedures to refine terms and adjust values used to calculate payment
599.35 rates in this section.

600.1 (b) The commissioner shall, within available resources, conduct research and
600.2 gather data and information from existing state systems or other outside sources on the
600.3 following items:

600.4 (1) differences in the underlying cost to provide services and care across the state; and

600.5 (2) mileage and utilization of transportation for all day and unit-based services.

600.6 (c) Using a statistically valid set of rates management system data, the commissioner,
600.7 in consultation with stakeholders, shall analyze for each service the average difference in
600.8 the rate on December 31, 2013, and the framework rate at the individual, provider, lead
600.9 agency, and state levels.

600.10 (d) The commissioner, in consultation with stakeholders, shall review and evaluate
600.11 the following values already in subdivisions 6 to 9, or issues that impact all services,
600.12 including, but not limited to:

600.13 (1) values for transportation rates for day services;

600.14 (2) values for transportation rates in residential services;

600.15 (3) values for services where monitoring technology replaces staff time;

600.16 (4) values for indirect services;

600.17 (5) values for nursing;

600.18 (6) component values for independent living skills;

600.19 (7) component values for family foster care that reflect licensing requirements;

600.20 (8) adjustments to other components to replace the budget neutrality factor;

600.21 (9) remote monitoring technology for nonresidential services;

600.22 (10) values for basic and intensive services in residential services;

600.23 (11) values for the facility use rate in day services;

600.24 (12) values for workers compensation as part of employee-related expenses;

600.25 (13) values for unemployment insurance as part of employee-related expenses;

600.26 (14) a component value to reflect costs for individuals with rates previously adjusted
600.27 for the inclusion of group residential housing rate 3 costs, only for any individual enrolled
600.28 as of December 31, 2013; and

600.29 (15) any changes in state or federal law with an impact on the underlying cost of
600.30 providing home and community-based services.

600.31 (e) The commissioner shall report to the chairs and the ranking minority members of
600.32 the legislative committees and divisions with jurisdiction over health and human services
600.33 policy and finance with the information and data gathered under paragraphs (b) to (d)
600.34 on the following dates:

600.35 (1) January 15, 2015, with preliminary results and data;

601.1 (2) January 15, 2016, with a status implementation update, and additional data
601.2 and summary information;

601.3 (3) January 15, 2017, with the full report; and

601.4 (4) January 15, 2019, with another full report, and a full report once every four
601.5 years thereafter.

601.6 (f) Based on the commissioner's evaluation of the information and data collected in
601.7 paragraphs (b) to (d), the commissioner may make recommendations to the legislature
601.8 to address any potential issues.

601.9 (g) The commissioner shall implement a regional adjustment factor to all rate
601.10 calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to
601.11 implementation, the commissioner shall consult with stakeholders on the methodology to
601.12 calculate the adjustment.

601.13 (h) The commissioner shall provide a public notice via LISTSERV in October of
601.14 each year beginning October 1, 2014, containing information detailing legislatively
601.15 approved changes in:

601.16 (1) calculation values including derived wage rates and related employee and
601.17 administrative factors;

601.18 (2) service utilization;

601.19 (3) county and tribal allocation changes; and

601.20 (4) information on adjustments made to calculation values and the timing of those
601.21 adjustments.

601.22 The information in this notice shall be effective January 1 of the following year.

601.23 Subd. 11. **Payment implementation.** Upon implementation of the payment
601.24 methodologies under this section, those payment rates supersede rates established in county
601.25 contracts for recipients receiving waiver services under section 256B.092 or 256B.49.

601.26 Subd. 12. **Customization of rates for individuals.** (a) For persons determined to
601.27 have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be
601.28 increased by an adjustment factor prior to calculating the rate under subdivisions 6, 7, 8,
601.29 and 9. The customization rate with respect to deaf or hard-of-hearing persons shall be
601.30 \$2.50 per hour for waiver recipients who meet the respective criteria as determined by
601.31 the commissioner.

601.32 (b) For the purposes of this section, "deaf and hard-of-hearing" means:

601.33 (1) the person has a developmental disability and an assessment score which
601.34 indicates a hearing impairment that is severe or that the person has no useful hearing;

601.35 (2) the person has a developmental disability and an expressive communications
601.36 score that indicates the person uses single signs or gestures, uses an augmentative

602.1 communication aid, or does not have functional communication, or the person's expressive
602.2 communications is unknown; and

602.3 (3) the person has a developmental disability and a communication score which
602.4 indicates the person comprehends signs, gestures and modeling prompts or does not
602.5 comprehend verbal, visual or gestural communication or that the person's receptive
602.6 communication score is unknown; or

602.7 (4) the person receives long-term care services and has an assessment score that
602.8 indicates they hear only very loud sounds, have no useful hearing, or a determination
602.9 cannot be made; and the person receives long-term care services and has an assessment
602.10 that indicates the person communicates needs with sign language, symbol board, written
602.11 messages, gestures or an interpreter; communicates with inappropriate content, makes
602.12 garbled sounds or displays echolalia, or does not communicate needs.

602.13 Subd. 13. **Transportation.** The commissioner shall require that the purchase
602.14 of transportation services be cost-effective and be limited to market rates where the
602.15 transportation mode is generally available and accessible.

602.16 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead
602.17 agencies must identify individuals with exceptional needs that cannot be met under the
602.18 disability waiver rate system. The commissioner shall use that information to evaluate
602.19 and, if necessary, approve an alternative payment rate for those individuals.

602.20 (b) Lead agencies must submit exception requests to the state.

602.21 (c) An application for a rate exception may be submitted for the following criteria:

602.22 (1) an individual has service needs that cannot be met through additional units
602.23 of service; or

602.24 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results in an
602.25 individual being discharged.

602.26 (d) Exception requests must include the following information:

602.27 (1) the service needs required by each individual that are not accounted for in
602.28 subdivisions 6, 7, 8, and 9;

602.29 (2) the service rate requested and the difference from the rate determined in
602.30 subdivisions 6, 7, 8, and 9;

602.31 (3) a basis for the underlying costs used for the rate exception and any accompanying
602.32 documentation;

602.33 (4) the duration of the rate exception; and

602.34 (5) any contingencies for approval.

602.35 (e) Approved rate exceptions shall be managed within lead agency allocations under
602.36 sections 256B.092 and 256B.49.

603.1 (f) Individual disability waiver recipients may request that a lead agency submit an
603.2 exception request. A lead agency that denies such a request shall notify the individual
603.3 waiver recipient of its decision and the reasons for denying the request in writing no later
603.4 than 30 days after the individual's request has been made.

603.5 (g) The commissioner shall determine whether to approve or deny an exception
603.6 request no more than 30 days after receiving the request. If the commissioner denies the
603.7 request, the commissioner shall notify the lead agency and the individual disability waiver
603.8 recipient in writing of the reasons for the denial.

603.9 (h) The individual disability waiver recipient may appeal any denial of an exception
603.10 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
603.11 256.0451. When the denial of an exception request results in the proposed demission of a
603.12 waiver recipient from a residential or day habilitation program, the commissioner shall
603.13 issue a temporary stay of demission, when requested by the disability waiver recipient,
603.14 consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c).
603.15 The temporary stay shall remain in effect until the lead agency can provide an informed
603.16 choice of appropriate, alternative services to the disability waiver.

603.17 (i) Providers may petition lead agencies to update values that were entered
603.18 incorrectly or erroneously into the rate management system, based on past service level
603.19 discussions and determination in subdivision 4, without applying for a rate exception.

603.20 Subd. 15. **County or tribal allocations.** (a) Upon implementation of the disability
603.21 waiver rates management system on January 1, 2014, the commissioner shall establish
603.22 a method of tracking and reporting the fiscal impact of the disability waiver rates
603.23 management system on individual lead agencies.

603.24 (b) Beginning January 1, 2014, the commissioner shall make annual adjustments to
603.25 lead agencies' home and community-based waived service budget allocations to adjust
603.26 for rate differences and the resulting impact on county allocations upon implementation of
603.27 the disability waiver rates system.

603.28 Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the
603.29 following adjustments to the rate generated by the framework to assure budget neutrality
603.30 until the rate information is available to implement paragraph (b). The rate generated by
603.31 the framework shall be multiplied by the appropriate factor, as designated below:

603.32 (1) for residential services: 1.003;

603.33 (2) for day services: 1.000;

603.34 (3) for unit-based services with programming: 0.941; and

603.35 (4) for unit-based services without programming: 0.796.

604.1 (b) Within 12 months of January 1, 2014, the commissioner shall compare estimated
604.2 spending for all home and community-based waiver services under the new payment rates
604.3 defined in subdivisions 6 to 9 with estimated spending for the same recipients and services
604.4 under the rates in effect on July 1, 2013. This comparison must distinguish spending under
604.5 each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients
604.6 and services for one or more service months after the new rates have gone into effect.
604.7 The commissioner shall consult with the commissioner of management and budget on
604.8 this analysis to ensure budget neutrality. If estimated spending under the new rates for
604.9 services under one or more subdivisions differs in this comparison by 0.3 percent or
604.10 more, the commissioner shall assure aggregate budget neutrality across all service areas
604.11 by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total
604.12 estimated spending for each subdivision under the new rates matches estimated spending
604.13 under the rates in effect on July 1, 2013.

604.14 Sec. 13. **FEDERAL APPROVAL.**

604.15 During the transition to a new disability waivers payment methodology system, the
604.16 commissioner of human services has the authority to manage the disability home and
604.17 community-based service waiver programs within federally required parameters. The
604.18 commissioner may negotiate an agreement with the Centers for Medicare and Medicaid
604.19 Services for the implementation of the disability waivers payment methodology system
604.20 in order to prevent federal action that would withhold or disallow federal funding for
604.21 current waiver recipients, or new waiver recipients as authorized by the legislature. The
604.22 commissioner must provide for public notice and comment, as required by state and
604.23 federal law, to changes related to federal approval of the disability waivers payment
604.24 methodology system. If the Centers for Medicare and Medicaid Services requires
604.25 changes to the disability waivers payment rate methodology implementation plan, the
604.26 commissioner shall implement the changes in accordance with Minnesota Statutes, section
604.27 256B.4914, subdivision 16, and upon:

604.28 (1) public notice;

604.29 (2) federal approval;

604.30 (3) Legislative Advisory Commission review and recommendation, in a manner
604.31 described under Minnesota Statutes, section 3.3005, subdivision 4; and

604.32 (4) recommendation of necessary legislation to the chairs and ranking minority
604.33 members of the legislative committees with jurisdiction over health and human services
604.34 policy and finance by January 15, 2014. The changed implementation plan must provide
604.35 for a transition from the historical to the new rate setting methodology.

605.1 Sec. 14. **REPEALER.**

605.2 (a) Minnesota Statutes 2012, sections 252.40; 252.46, subdivisions 1, 2, 3, 4, 5, 6,
 605.3 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, and 21; 256B.4913, subdivisions 1, 2, 3, and 4; and
 605.4 256B.501, subdivision 8, are repealed effective January 1, 2014.

605.5 (b) Minnesota Rules, part 9525.1860, subparts 3, items B and C and 4, item D, are
 605.6 repealed effective January 1, 2014.

605.7 **ARTICLE 14**

605.8 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

605.9 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

605.10 The sums shown in the columns marked "Appropriations" are appropriated to the
 605.11 agencies and for the purposes specified in this article. The appropriations are from the
 605.12 general fund, or another named fund, and are available for the fiscal years indicated
 605.13 for each purpose. The figures "2014" and "2015" used in this article mean that the
 605.14 appropriations listed under them are available for the fiscal year ending June 30, 2014, or
 605.15 June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal
 605.16 year 2015. "The biennium" is fiscal years 2014 and 2015.

605.17		<u>APPROPRIATIONS</u>
605.18		<u>Available for the Year</u>
605.19		<u>Ending June 30</u>
605.20		<u>2014</u> <u>2015</u>

605.21 Sec. 2. **COMMISSIONER OF HUMAN**
 605.22 **SERVICES**

605.23 Subdivision 1. **Total Appropriation** \$ **6,438,485,000** \$ **6,457,117,000**

605.24	<u>Appropriations by Fund</u>		
605.25		<u>2014</u>	<u>2015</u>
605.26	<u>General</u>	<u>5,654,765,000</u>	<u>5,677,458,000</u>
605.27	<u>State Government</u>		
605.28	<u>Special Revenue</u>	<u>4,099,000</u>	<u>4,510,000</u>
605.29	<u>Health Care Access</u>	<u>519,816,000</u>	<u>518,446,000</u>
605.30	<u>Federal TANF</u>	<u>257,915,000</u>	<u>254,813,000</u>
605.31	<u>Lottery Prize Fund</u>	<u>1,890,000</u>	<u>1,890,000</u>

605.32 **Receipts for Systems Projects.**

605.33 Appropriations and federal receipts for
 605.34 information systems projects for MAXIS,
 605.35 PRISM, MMIS, and SSIS must be deposited
 605.36 in the state system account authorized

606.1 in Minnesota Statutes, section 256.014.
606.2 Money appropriated for computer projects
606.3 approved by the commissioner of Minnesota
606.4 information technology services, funded
606.5 by the legislature, and approved by the
606.6 commissioner of management and budget,
606.7 may be transferred from one project to
606.8 another and from development to operations
606.9 as the commissioner of human services
606.10 considers necessary. Any unexpended
606.11 balance in the appropriation for these
606.12 projects does not cancel but is available for
606.13 ongoing development and operations.

606.14 **Nonfederal Share Transfers.** The
606.15 nonfederal share of activities for which
606.16 federal administrative reimbursement is
606.17 appropriated to the commissioner may be
606.18 transferred to the special revenue fund.

606.19 **ARRA Supplemental Nutrition Assistance**
606.20 **Benefit Increases.** The funds provided for
606.21 food support benefit increases under the
606.22 Supplemental Nutrition Assistance Program
606.23 provisions of the American Recovery and
606.24 Reinvestment Act (ARRA) of 2009 must be
606.25 used for benefit increases beginning July 1,
606.26 2009.

606.27 **Supplemental Nutrition Assistance**
606.28 **Program Employment and Training.**
606.29 (1) Notwithstanding Minnesota Statutes,
606.30 sections 256D.051, subdivisions 1a, 6b,
606.31 and 6c, and 256J.626, federal Supplemental
606.32 Nutrition Assistance employment and
606.33 training funds received as reimbursement of
606.34 MFIP consolidated fund grant expenditures
606.35 for diversionary work program participants

607.1 and child care assistance program
607.2 expenditures must be deposited in the general
607.3 fund. The amount of funds must be limited to
607.4 \$4,900,000 per year in fiscal years 2014 and
607.5 2015, and to \$4,400,000 per year in fiscal
607.6 years 2016 and 2017, contingent on approval
607.7 by the federal Food and Nutrition Service.

607.8 (2) Consistent with the receipt of the federal
607.9 funds, the commissioner may adjust the
607.10 level of working family credit expenditures
607.11 claimed as TANF maintenance of effort.
607.12 Notwithstanding any contrary provision in
607.13 this article, this rider expires June 30, 2017.

607.14 **TANF Maintenance of Effort.** (a) In order
607.15 to meet the basic maintenance of effort
607.16 (MOE) requirements of the TANF block grant
607.17 specified under Code of Federal Regulations,
607.18 title 45, section 263.1, the commissioner may
607.19 only report nonfederal money expended for
607.20 allowable activities listed in the following
607.21 clauses as TANF/MOE expenditures:

607.22 (1) MFIP cash, diversionary work program,
607.23 and food assistance benefits under Minnesota
607.24 Statutes, chapter 256J;

607.25 (2) the child care assistance programs
607.26 under Minnesota Statutes, sections 119B.03
607.27 and 119B.05, and county child care
607.28 administrative costs under Minnesota
607.29 Statutes, section 119B.15;

607.30 (3) state and county MFIP administrative
607.31 costs under Minnesota Statutes, chapters
607.32 256J and 256K;

- 608.1 (4) state, county, and tribal MFIP
608.2 employment services under Minnesota
608.3 Statutes, chapters 256J and 256K;
- 608.4 (5) expenditures made on behalf of legal
608.5 noncitizen MFIP recipients who qualify for
608.6 the MinnesotaCare program under Minnesota
608.7 Statutes, chapter 256L;
- 608.8 (6) qualifying working family credit
608.9 expenditures under Minnesota Statutes,
608.10 section 290.0671;
- 608.11 (7) qualifying Minnesota education credit
608.12 expenditures under Minnesota Statutes,
608.13 section 290.0674; and
- 608.14 (8) qualifying Head Start expenditures under
608.15 Minnesota Statutes, section 119A.50.
- 608.16 (b) The commissioner shall ensure that
608.17 sufficient qualified nonfederal expenditures
608.18 are made each year to meet the state's
608.19 TANF/MOE requirements. For the activities
608.20 listed in paragraph (a), clauses (2) to
608.21 (8), the commissioner may only report
608.22 expenditures that are excluded from the
608.23 definition of assistance under Code of
608.24 Federal Regulations, title 45, section 260.31.
- 608.25 (c) For fiscal years beginning with state fiscal
608.26 year 2003, the commissioner shall ensure
608.27 that the maintenance of effort used by the
608.28 commissioner of management and budget
608.29 for the February and November forecasts
608.30 required under Minnesota Statutes, section
608.31 16A.103, contains expenditures under
608.32 paragraph (a), clause (1), equal to at least 16
608.33 percent of the total required under Code of
608.34 Federal Regulations, title 45, section 263.1.

609.1 (d) The requirement in Minnesota Statutes,
609.2 section 256.011, subdivision 3, that federal
609.3 grants or aids secured or obtained under that
609.4 subdivision be used to reduce any direct
609.5 appropriations provided by law, do not apply
609.6 if the grants or aids are federal TANF funds.

609.7 (e) For the federal fiscal years beginning on
609.8 or after October 1, 2007, the commissioner
609.9 may not claim an amount of TANF/MOE in
609.10 excess of the 75 percent standard in Code
609.11 of Federal Regulations, title 45, section
609.12 263.1(a)(2), except:

609.13 (1) to the extent necessary to meet the 80
609.14 percent standard under Code of Federal
609.15 Regulations, title 45, section 263.1(a)(1),
609.16 if it is determined by the commissioner
609.17 that the state will not meet the TANF work
609.18 participation target rate for the current year;

609.19 (2) to provide any additional amounts
609.20 under Code of Federal Regulations, title 45,
609.21 section 264.5, that relate to replacement of
609.22 TANF funds due to the operation of TANF
609.23 penalties; and

609.24 (3) to provide any additional amounts that
609.25 may contribute to avoiding or reducing
609.26 TANF work participation penalties through
609.27 the operation of the excess MOE provisions
609.28 of Code of Federal Regulations, title 45,
609.29 section 261.43(a)(2).

609.30 For the purposes of clauses (1) to (3),
609.31 the commissioner may supplement the
609.32 MOE claim with working family credit
609.33 expenditures or other qualified expenditures
609.34 to the extent such expenditures are otherwise
609.35 available after considering the expenditures

610.1 allowed in this subdivision and subdivisions

610.2 2 and 3.

610.3 (f) Notwithstanding any contrary provision

610.4 in this article, paragraphs (a) to (e) expire

610.5 June 30, 2017.

610.6 **Working Family Credit Expenditures**

610.7 **as TANF/MOE.** The commissioner may

610.8 claim as TANF maintenance of effort up to

610.9 \$6,707,000 per year of working family credit

610.10 expenditures in each fiscal year.

610.11 **Subd. 2. Working Family Credit to be Claimed**

610.12 **for TANF/MOE**

610.13 The commissioner may count the following

610.14 amounts of working family credit

610.15 expenditures as TANF/MOE:

610.16 (1) fiscal year 2014, \$50,272,000;

610.17 (2) fiscal year 2015, \$34,894,000;

610.18 (3) fiscal year 2016, \$0; and

610.19 (4) fiscal year 2017, \$1,283,000.

610.20 **Subd. 3. TANF Transfer to Federal Child Care**

610.21 **and Development Fund**

610.22 (a) The following TANF fund amounts

610.23 are appropriated to the commissioner for

610.24 purposes of MFIP/transition year child care

610.25 assistance under Minnesota Statutes, section

610.26 119B.05:

610.27 (1) fiscal year 2014; \$14,020,000; and

610.28 (2) fiscal year 2015, \$14,020,000.

610.29 (b) The commissioner shall authorize the

610.30 transfer of sufficient TANF funds to the

610.31 federal child care and development fund to

610.32 meet this appropriation and shall ensure that

610.33 all transferred funds are expended according

611.1 to federal child care and development fund
 611.2 regulations.

611.3 Subd. 4. **Central Office**

611.4 The amounts that may be spent from this
 611.5 appropriation for each purpose are as follows:

611.6 **(a) Operations**

611.7	<u>Appropriations by Fund</u>	
611.8 <u>General</u>	<u>101,979,000</u>	<u>96,858,000</u>
611.9 <u>State Government</u>		
611.10 <u>Special Revenue</u>	<u>3,974,000</u>	<u>4,385,000</u>
611.11 <u>Health Care Access</u>	<u>13,177,000</u>	<u>13,004,000</u>
611.12 <u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

611.13 **DHS Receipt Center Accounting.** The
 611.14 commissioner is authorized to transfer
 611.15 appropriations to, and account for DHS
 611.16 receipt center operations in, the special
 611.17 revenue fund.

611.18 **Administrative Recovery; Set-Aside.** The
 611.19 commissioner may invoice local entities
 611.20 through the SWIFT accounting system as an
 611.21 alternative means to recover the actual cost
 611.22 of administering the following provisions:

611.23 (1) Minnesota Statutes, section 125A.744,
 611.24 subdivision 3;

611.25 (2) Minnesota Statutes, section 245.495,
 611.26 paragraph (b);

611.27 (3) Minnesota Statutes, section 256B.0625,
 611.28 subdivision 20, paragraph (k);

611.29 (4) Minnesota Statutes, section 256B.0924,
 611.30 subdivision 6, paragraph (g);

611.31 (5) Minnesota Statutes, section 256B.0945,
 611.32 subdivision 4, paragraph (d); and

612.1 (6) Minnesota Statutes, section 256F.10,
612.2 subdivision 6, paragraph (b).

612.3 **Systems Modernization.** The following
612.4 amounts are appropriated for transfer to
612.5 the state systems account authorized in
612.6 Minnesota Statutes, section 256.014:

612.7 (1) \$1,825,000 in fiscal year 2014 and
612.8 \$2,502,000 in fiscal year 2015 is for the
612.9 state share of Medicaid-allocated costs of
612.10 the health insurance exchange information
612.11 technology and operational structure. The
612.12 funding base is \$3,222,000 in fiscal year 2016
612.13 and \$3,037,000 in fiscal year 2017 but shall
612.14 not be included in the base thereafter; and

612.15 (2) \$9,344,000 in fiscal year 2014 and
612.16 \$3,660,000 in fiscal year 2015 are for the
612.17 modernization and streamlining of agency
612.18 eligibility and child support systems. The
612.19 funding base is \$5,921,000 in fiscal year
612.20 2016 and \$1,792,000 in fiscal year 2017 but
612.21 shall not be included in the base thereafter.

612.22 The unexpended balance of the \$9,344,000
612.23 appropriation in fiscal year 2014 and the
612.24 \$3,660,000 appropriation in fiscal year 2015
612.25 must be transferred from the Department of
612.26 Human Services state systems account to
612.27 the Office of Enterprise Technology when
612.28 the Office of Enterprise Technology has
612.29 negotiated a federally approved internal
612.30 service fund rates and billing process with
612.31 sufficient internal accounting controls to
612.32 properly maximize federal reimbursement
612.33 to Minnesota for human services system
612.34 modernization projects, but not later than
612.35 June 30, 2015.

613.1 If contingent funding is fully or partially
 613.2 disbursed under article 15, section 3, and
 613.3 transferred to the state systems account, the
 613.4 unexpended balance of that appropriation
 613.5 must be transferred to the Office of Enterprise
 613.6 Technology in accordance with this clause.
 613.7 Contingent funding must not exceed
 613.8 \$11,598,000 for the biennium.

613.9 **Base Adjustment.** The general fund base
 613.10 is increased by \$2,868,000 in fiscal year
 613.11 2016 and decreased by \$1,206,000 in fiscal
 613.12 year 2017. The health access fund base is
 613.13 decreased by \$551,000 in fiscal years 2016
 613.14 and 2017. The state government special
 613.15 revenue fund base is increased by \$4,000 in
 613.16 fiscal year 2016 and decreased by \$236,000
 613.17 in fiscal year 2017.

613.18 **(b) Children and Families**

613.19	<u>Appropriations by Fund</u>		
613.20	<u>General</u>	<u>8,023,000</u>	<u>8,015,000</u>
613.21	<u>Federal TANF</u>	<u>2,282,000</u>	<u>2,282,000</u>

613.22 **Financial Institution Data Match and**
 613.23 **Payment of Fees.** The commissioner is
 613.24 authorized to allocate up to \$310,000 each
 613.25 year in fiscal years 2014 and 2015 from the
 613.26 PRISM special revenue account to make
 613.27 payments to financial institutions in exchange
 613.28 for performing data matches between account
 613.29 information held by financial institutions
 613.30 and the public authority's database of child
 613.31 support obligors as authorized by Minnesota
 613.32 Statutes, section 13B.06, subdivision 7.

613.33 **Base Adjustment.** The general fund base is
 613.34 decreased by \$300,000 in fiscal years 2016

614.1 and 2017. The TANF fund base is increased
 614.2 by \$300,000 in fiscal years 2016 and 2017.

614.3 **(c) Health Care**

614.4	<u>Appropriations by Fund</u>		
614.5	<u>General</u>	<u>14,028,000</u>	<u>13,826,000</u>
614.6	<u>Health Care Access</u>	<u>28,442,000</u>	<u>31,137,000</u>

614.7 **Base Adjustment.** The general fund base
 614.8 is decreased by \$86,000 in fiscal year 2016
 614.9 and by \$86,000 in fiscal year 2017. The
 614.10 health care access fund base is increased
 614.11 by \$6,954,000 in fiscal year 2016 and by
 614.12 \$5,489,000 in fiscal year 2017.

614.13 **(d) Continuing Care**

614.14	<u>Appropriations by Fund</u>		
614.15	<u>General</u>	<u>20,993,000</u>	<u>22,359,000</u>
614.16	<u>State Government</u>		
614.17	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

614.18 **Base Adjustment.** The general fund base is
 614.19 increased by \$1,690,000 in fiscal year 2016
 614.20 and by \$798,000 in fiscal year 2017.

614.21 **(e) Chemical and Mental Health**

614.22	<u>Appropriations by Fund</u>		
614.23	<u>General</u>	<u>4,639,000</u>	<u>4,490,000</u>
614.24	<u>Lottery Prize Fund</u>	<u>157,000</u>	<u>157,000</u>

614.25 **Subd. 5. Forecasted Programs**

614.26 The amounts that may be spent from this
 614.27 appropriation for each purpose are as follows:

614.28 **(a) MFIP/DWP**

614.29	<u>Appropriations by Fund</u>		
614.30	<u>General</u>	<u>72,583,000</u>	<u>76,927,000</u>
614.31	<u>Federal TANF</u>	<u>80,342,000</u>	<u>76,851,000</u>

614.32 **(b) MFIP Child Care Assistance** 61,701,000 69,294,000

614.33 **(c) General Assistance** 54,787,000 56,068,000

615.1 **General Assistance Standard.** The
 615.2 commissioner shall set the monthly standard
 615.3 of assistance for general assistance units
 615.4 consisting of an adult recipient who is
 615.5 childless and unmarried or living apart
 615.6 from parents or a legal guardian at \$203.
 615.7 The commissioner may reduce this amount
 615.8 according to Laws 1997, chapter 85, article
 615.9 3, section 54.

615.10 **Emergency General Assistance.** The
 615.11 amount appropriated for emergency general
 615.12 assistance funds is limited to no more
 615.13 than \$6,729,812 in fiscal year 2014 and
 615.14 \$6,729,812 in fiscal year 2015. Funds
 615.15 to counties shall be allocated by the
 615.16 commissioner using the allocation method in
 615.17 Minnesota Statutes, section 256D.06.

615.18	<u>(d) MN Supplemental Assistance</u>	<u>38,646,000</u>	<u>39,821,000</u>
615.19	<u>(e) Group Residential Housing</u>	<u>141,138,000</u>	<u>150,988,000</u>
615.20	<u>(f) MinnesotaCare</u>	<u>297,707,000</u>	<u>247,284,000</u>

615.21 This appropriation is from the health care
 615.22 access fund.

615.23 **(g) Medical Assistance**

615.24	<u>Appropriations by Fund</u>		
615.25	<u>General</u>	<u>4,443,768,000</u>	<u>4,431,612,000</u>
615.26	<u>Health Care Access</u>	<u>179,550,000</u>	<u>226,081,000</u>

615.27 **Spending to be apportioned.** The
 615.28 commissioner shall apportion expenditures
 615.29 under this paragraph consistent with the
 615.30 requirements of section 12.

615.31 **Support Services for Deaf and**
 615.32 **Hard-of-Hearing.** \$121,000 in fiscal
 615.33 year 2014 and \$141,000 in fiscal year 2015;
 615.34 and \$10,000 in fiscal year 2014 and \$13,000

616.1 in fiscal year 2015 are from the health care
 616.2 access fund for the hospital reimbursement
 616.3 increase in Minnesota Statutes, section
 616.4 256.969, subdivision 29, paragraph (b).

616.5 **Disproportionate Share Payments.**

616.6 Effective for services provided on or after
 616.7 July 1, 2011, through June 30, 2015, the
 616.8 commissioner of human services shall
 616.9 deposit, in the health care access fund,
 616.10 additional federal matching funds received
 616.11 under Minnesota Statutes, section 256B.199,
 616.12 paragraph (e), as disproportionate share
 616.13 hospital payments for inpatient hospital
 616.14 services provided under MinnesotaCare to
 616.15 lawfully present noncitizens who are not
 616.16 eligible for MinnesotaCare with federal
 616.17 financial participation due to immigration
 616.18 status. The amount deposited shall not exceed
 616.19 \$2,200,000 for the time period specified.

616.20 **Funding for Services Provided to EMA**

616.21 **Recipients.** \$2,200,000 in fiscal year 2014 is
 616.22 from the health care access fund to provide
 616.23 services to emergency medical assistance
 616.24 recipients under Minnesota Statutes, section
 616.25 256B.06, subdivision 4, paragraph (l). This
 616.26 is a onetime appropriation and is available in
 616.27 either year of the biennium.

616.28 <u>(h) Alternative Care</u>	<u>50,776,000</u>	<u>54,922,000</u>
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616.29 **Alternative Care Transfer.** Any money
 616.30 allocated to the alternative care program that
 616.31 is not spent for the purposes indicated does
 616.32 not cancel but shall be transferred to the
 616.33 medical assistance account.

616.34 <u>(i) CD Treatment Fund</u>	<u>81,440,000</u>	<u>74,875,000</u>
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617.1 **Balance Transfer.** The commissioner must
 617.2 transfer \$18,188,000 from the consolidated
 617.3 chemical dependency treatment fund to the
 617.4 general fund by September 30, 2013.

617.5 **Subd. 6. Grant Programs**

617.6 The amounts that may be spent from this
 617.7 appropriation for each purpose are as follows:

617.8 **(a) Support Services Grants**

617.9		<u>Appropriations by Fund</u>	
617.10	<u>General</u>	<u>8,915,000</u>	<u>13,333,000</u>
617.11	<u>Federal TANF</u>	<u>94,611,000</u>	<u>94,611,000</u>

617.12 **Paid Work Experience.** \$2,168,000
 617.13 each year in fiscal years 2015 and 2016
 617.14 is from the general fund for paid work
 617.15 experience for long-term MFIP recipients.
 617.16 Paid work includes full and partial wage
 617.17 subsidies and other related services such as
 617.18 job development, marketing, preworksite
 617.19 training, job coaching, and postplacement
 617.20 services. These are onetime appropriations.
 617.21 Unexpended funds for fiscal year 2015 do not
 617.22 cancel, but are available to the commissioner
 617.23 for this purpose in fiscal year 2016.

617.24 **Work Study Funding for MFIP**
 617.25 **Participants.** \$250,000 each year in fiscal
 617.26 years 2015 and 2016 is from the general fund
 617.27 to pilot work study jobs for MFIP recipients
 617.28 in approved postsecondary education
 617.29 programs. This is a onetime appropriation.
 617.30 Unexpended funds for fiscal year 2015 do
 617.31 not cancel, but are available for this purpose
 617.32 in fiscal year 2016.

617.33 **Local Strategies to Reduce Disparities.**
 617.34 \$2,000,000 each year in fiscal years 2015

618.1 and 2016 is from the general fund for
618.2 local projects that focus on services for
618.3 subgroups within the MFIP caseload
618.4 who are experiencing poor employment
618.5 outcomes. These are onetime appropriations.
618.6 Unexpended funds for fiscal year 2015 do not
618.7 cancel, but are available to the commissioner
618.8 for this purpose in fiscal year 2016.

618.9 **Home Visiting Collaborations for MFIP**
618.10 **Teen Parents.** \$200,000 per year in fiscal
618.11 years 2014 and 2015 is from the general fund
618.12 and \$200,000 in fiscal year 2016 is from the
618.13 federal TANF fund for technical assistance
618.14 and training to support local collaborations
618.15 that provide home visiting services for
618.16 MFIP teen parents. The general fund
618.17 appropriation is onetime. The federal TANF
618.18 fund appropriation is added to the base.

618.19 **Performance Bonus Funds for Counties.**
618.20 The TANF fund base is increased by
618.21 \$1,500,000 each year in fiscal years 2016
618.22 and 2017. The commissioner must allocate
618.23 this amount each year to counties that exceed
618.24 their expected range of performance on the
618.25 annualized three-year self-support index
618.26 as defined in Minnesota Statutes, section
618.27 256J.751, subdivision 2, clause (6). This is a
618.28 permanent base adjustment. Notwithstanding
618.29 any contrary provisions in this article, this
618.30 provision expires June 30, 2016.

618.31 **Base Adjustment.** The general fund base is
618.32 decreased by \$200,000 in fiscal year 2016
618.33 and \$4,618,000 in fiscal year 2017. The
618.34 TANF fund base is increased by \$1,700,000
618.35 in fiscal years 2016 and 2017.

619.1 **(b) Basic Sliding Fee Child Care Assistance**
 619.2 **Grants** 36,836,000 42,318,000

619.3 **Base Adjustment.** The general fund base is
 619.4 increased by \$3,778,000 in fiscal year 2016
 619.5 and by \$3,849,000 in fiscal year 2017.

619.6 **(c) Child Care Development Grants** 1,612,000 1,737,000

619.7 **(d) Child Support Enforcement Grants** 50,000 50,000

619.8 **Federal Child Support Demonstration**

619.9 **Grants.** Federal administrative
 619.10 reimbursement resulting from the federal
 619.11 child support grant expenditures authorized
 619.12 under United States Code, title 42, section
 619.13 1315, is appropriated to the commissioner
 619.14 for this activity.

619.15 **(e) Children's Services Grants**

619.16	<u>Appropriations by Fund</u>	
619.17	<u>General</u>	<u>49,760,000</u> <u>52,961,000</u>
619.18	<u>Federal TANF</u>	<u>140,000</u> <u>140,000</u>

619.19 **Adoption Assistance and Relative Custody**

619.20 **Assistance.** \$37,453,000 in fiscal year 2014
 619.21 and \$37,453,000 in fiscal year 2015 is for
 619.22 the adoption assistance and relative custody
 619.23 assistance programs. The commissioner
 619.24 shall determine with the commissioner of
 619.25 Minnesota Management and Budget the
 619.26 appropriation for Northstar Care for Children
 619.27 effective January 1, 2015. The commissioner
 619.28 may transfer appropriations for adoption
 619.29 assistance, relative custody assistance, and
 619.30 Northstar Care for Children between fiscal
 619.31 years and among programs to adjust for
 619.32 transfers across the programs.

619.33 **Title IV-E Adoption Assistance.** Additional
 619.34 federal reimbursements to the state as a result

620.1 of the Fostering Connections to Success
 620.2 and Increasing Adoptions Act's expanded
 620.3 eligibility for Title IV-E adoption assistance
 620.4 are appropriated for postadoption services,
 620.5 including a parent-to-parent support network.

620.6 **Privatized Adoption Grants.** Federal
 620.7 reimbursement for privatized adoption grant
 620.8 and foster care recruitment grant expenditures
 620.9 is appropriated to the commissioner for
 620.10 adoption grants and foster care and adoption
 620.11 administrative purposes.

620.12 **Adoption Assistance Incentive Grants.**
 620.13 Federal funds available during fiscal years
 620.14 2014 and 2015 for adoption incentive grants
 620.15 are appropriated for postadoption services,
 620.16 including a parent-to-parent support network.

620.17 **Base Adjustment.** The general fund base is
 620.18 increased by \$5,913,000 in fiscal year 2016
 620.19 and by \$10,297,000 in fiscal year 2017.

620.20	<u>(f) Child and Community Service Grants</u>	<u>53,301,000</u>	<u>53,301,000</u>
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620.21	<u>(g) Child and Economic Support Grants</u>	<u>21,047,000</u>	<u>20,848,000</u>
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620.22 **Minnesota Food Assistance Program.**
 620.23 Unexpended funds for the Minnesota food
 620.24 assistance program for fiscal year 2014 do
 620.25 not cancel but are available for this purpose
 620.26 in fiscal year 2015.

620.27 **Transitional Housing.** \$250,000 each year
 620.28 is for the transitional housing programs under
 620.29 Minnesota Statutes, section 256E.33.

620.30 **Emergency Services.** \$250,000 each year
 620.31 is for emergency services grants under
 620.32 Minnesota Statutes, section 256E.36.

621.1 **Family Assets for Independence. \$250,000**
 621.2 each year is for the Family Assets for
 621.3 Independence Minnesota program. This
 621.4 appropriation is available in either year of the
 621.5 biennium and may be transferred between
 621.6 fiscal years.

621.7 **Food Shelf Programs. \$375,000 in fiscal**
 621.8 year 2014 and \$375,000 in fiscal year
 621.9 2015 are for food shelf programs under
 621.10 Minnesota Statutes, section 256E.34. If the
 621.11 appropriation for either year is insufficient,
 621.12 the appropriation for the other year is
 621.13 available for it. Notwithstanding Minnesota
 621.14 Statutes, section 256E.34, subdivision 4, no
 621.15 portion of this appropriation may be used
 621.16 by Hunger Solutions for its administrative
 621.17 expenses, including but not limited to rent
 621.18 and salaries.

621.19 **Homeless Youth Act. \$2,000,000 in fiscal**
 621.20 year 2014 and \$2,000,000 in fiscal year 2015
 621.21 is for purposes of Minnesota Statutes, section
 621.22 256K.45.

621.23 **Safe Harbor Shelter and Housing.**
 621.24 \$500,000 in fiscal year 2014 and \$500,000 in
 621.25 fiscal year 2015 is for a safe harbor shelter
 621.26 and housing fund for housing and supportive
 621.27 services for youth who are sexually exploited.

621.28 **(h) Health Care Grants**

621.29	<u>Appropriations by Fund</u>		
621.30	<u>General</u>	<u>190,000</u>	<u>190,000</u>
621.31	<u>Health Care Access</u>	<u>190,000</u>	<u>190,000</u>

621.32 **Emergency Medical Assistance Referral**
 621.33 **and Assistance Grants. (a) The**
 621.34 commissioner of human services shall
 621.35 award grants to nonprofit programs that

622.1 provide immigration legal services based
 622.2 on indigency to provide legal services for
 622.3 immigration assistance to individuals with
 622.4 emergency medical conditions or complex
 622.5 and chronic health conditions who are not
 622.6 currently eligible for medical assistance
 622.7 or other public health care programs, but
 622.8 who may meet eligibility requirements with
 622.9 immigration assistance.

622.10 (b) The grantees, in collaboration with
 622.11 hospitals and safety net providers, shall
 622.12 provide referral assistance to connect
 622.13 individuals identified in paragraph (a) with
 622.14 alternative resources and services to assist in
 622.15 meeting their health care needs. \$100,000
 622.16 is appropriated in fiscal year 2014 and
 622.17 \$100,000 in fiscal year 2015. This is a
 622.18 onetime appropriation.

622.19 **Base Adjustment.** The general fund is
 622.20 decreased by \$100,000 in fiscal year 2016
 622.21 and \$100,000 in fiscal year 2017.

622.22 <u>(i) Aging and Adult Services Grants</u>	<u>14,827,000</u>	<u>15,010,000</u>
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622.23 **Base Adjustment.** The general fund is
 622.24 increased by \$1,150,000 in fiscal year 2016
 622.25 and \$1,151,000 in fiscal year 2017.

622.26 **Community Service Development**
 622.27 **Grants and Community Services Grants.**
 622.28 Community service development grants and
 622.29 community services grants are reduced by
 622.30 \$1,150,000 each year. This is a onetime
 622.31 reduction.

622.32 <u>(j) Deaf and Hard-of-Hearing Grants</u>	<u>1,771,000</u>	<u>1,785,000</u>
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622.33 <u>(k) Disabilities Grants</u>	<u>18,605,000</u>	<u>18,823,000</u>
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623.1 **Advocating Change Together.** \$310,000 in
 623.2 fiscal year 2014 is for a grant to Advocating
 623.3 Change Together (ACT) to maintain and
 623.4 promote services for persons with intellectual
 623.5 and developmental disabilities throughout
 623.6 the state. This appropriation is onetime. Of
 623.7 this appropriation:

623.8 (1) \$120,000 is for direct costs associated
 623.9 with the delivery and evaluation of
 623.10 peer-to-peer training programs administered
 623.11 throughout the state, focusing on education,
 623.12 employment, housing, transportation, and
 623.13 voting;

623.14 (2) \$100,000 is for delivery of statewide
 623.15 conferences focusing on leadership and
 623.16 skill development within the disability
 623.17 community; and

623.18 (3) \$90,000 is for administrative and general
 623.19 operating costs associated with managing
 623.20 or maintaining facilities, program delivery,
 623.21 staff, and technology.

623.22 **Base Adjustment.** The general fund base
 623.23 is increased by \$535,000 in fiscal year 2016
 623.24 and by \$709,000 in fiscal year 2017.

623.25 **(I) Adult Mental Health Grants**

	<u>Appropriations by Fund</u>	
623.26		
623.27	<u>General</u>	<u>71,199,000</u> <u>69,530,000</u>
623.28	<u>Health Care Access</u>	<u>750,000</u> <u>750,000</u>
623.29	<u>Lottery Prize</u>	<u>1,733,000</u> <u>1,733,000</u>

623.30 **Problem Gambling.** \$225,000 in fiscal year
 623.31 2014 and \$225,000 in fiscal year 2015 is
 623.32 appropriated from the lottery prize fund for a
 623.33 grant to the state affiliate recognized by the
 623.34 National Council on Problem Gambling. The

624.1 affiliate must provide services to increase
624.2 public awareness of problem gambling,
624.3 education and training for individuals and
624.4 organizations providing effective treatment
624.5 services to problem gamblers and their
624.6 families, and research relating to problem
624.7 gambling.

624.8 **Funding Usage.** Up to 75 percent of a fiscal
624.9 year's appropriations for adult mental health
624.10 grants may be used to fund allocations in that
624.11 portion of the fiscal year ending December
624.12 31.

624.13 **Base Adjustment.** The general fund base is
624.14 decreased by \$4,427,000 in fiscal years 2016
624.15 and 2017.

624.16 **Mental Health Pilot Project.** \$230,000
624.17 each year is for a grant to the Zumbro
624.18 Valley Mental Health Center. The grant
624.19 shall be used to implement a pilot project
624.20 to test an integrated behavioral health care
624.21 coordination model. The grant recipient must
624.22 report measurable outcomes and savings
624.23 to the commissioner of human services
624.24 by January 15, 2016. This is a onetime
624.25 appropriation.

624.26 **High-risk adults.** \$200,000 in fiscal
624.27 year 2014 is for a grant to the nonprofit
624.28 organization selected to administer the
624.29 demonstration project for high-risk adults
624.30 under Laws 2007, chapter 54, article 1,
624.31 section 19, in order to complete the project.
624.32 This is a onetime appropriation.

624.33 **(m) Child Mental Health Grants** 18,246,000 20,636,000

625.1 **Text Message Suicide Prevention**

625.2 **Program.** \$625,000 in fiscal year 2014 and
625.3 \$625,000 in fiscal year 2015 is for a grant
625.4 to a nonprofit organization to establish and
625.5 implement a statewide text message suicide
625.6 prevention program. The program shall
625.7 implement a suicide prevention counseling
625.8 text line designed to use text messaging to
625.9 connect with crisis counselors and to obtain
625.10 emergency information and referrals to
625.11 local resources in the local community. The
625.12 program shall include training within schools
625.13 and communities to encourage the use of the
625.14 program.

625.15 **Mental Health First Aid Training.** \$22,000
625.16 in fiscal year 2014 and \$23,000 in fiscal
625.17 year 2015 is to train teachers, social service
625.18 personnel, law enforcement, and others who
625.19 come into contact with children with mental
625.20 illnesses, in children and adolescents mental
625.21 health first aid training.

625.22 **Funding Usage.** Up to 75 percent of a fiscal
625.23 year's appropriation for child mental health
625.24 grants may be used to fund allocations in that
625.25 portion of the fiscal year ending December
625.26 31.

625.27 **(n) CD Treatment Support Grants** 1,816,000 1,816,000

625.28 **SBIRT Training.** (1) \$300,000 each year is
625.29 for grants to train primary care clinicians to
625.30 provide substance abuse brief intervention
625.31 and referral to treatment (SBIRT). This is a
625.32 onetime appropriation. The commissioner of
625.33 human services shall apply to SAMHSA for
625.34 an SBIRT professional training grant.

626.1 (2) If the commissioner of human services
626.2 receives a grant under clause (1) funds
626.3 appropriated under this clause, equal to
626.4 the grant amount, up to the available
626.5 appropriation, shall be transferred to the
626.6 Minnesota Organization on Fetal Alcohol
626.7 Syndrome (MOFAS). MOFAS must use
626.8 the funds for grants. Grant recipients must
626.9 be selected from communities that are
626.10 not currently served by federal Substance
626.11 Abuse Prevention and Treatment Block
626.12 Grant funds. Grant money must be used to
626.13 reduce the rates of fetal alcohol syndrome
626.14 and fetal alcohol effects, and the number of
626.15 drug-exposed infants. Grant money may be
626.16 used for prevention and intervention services
626.17 and programs, including, but not limited to,
626.18 community grants, professional education,
626.19 public awareness, and diagnosis.

626.20 **Fetal Alcohol Syndrome Grant. \$180,000**
626.21 each year from the general fund is for a
626.22 grant to the Minnesota Organization on Fetal
626.23 Alcohol Syndrome (MOFAS) to support
626.24 nonprofit Fetal Alcohol Spectrum Disorders
626.25 (FASD) outreach prevention programs
626.26 in Olmsted County. This is a onetime
626.27 appropriation.

626.28 **Base Adjustment.** The general fund base is
626.29 decreased by \$480,000 in fiscal year 2016
626.30 and \$480,000 in fiscal year 2017.

626.31 **Subd. 7. State-Operated Services**

626.32 **Transfer Authority Related to**
626.33 **State-Operated Services.** Money
626.34 appropriated for state-operated services
626.35 may be transferred between fiscal years

627.1 of the biennium with the approval of the
 627.2 commissioner of management and budget.

627.3 The amounts that may be spent from the
 627.4 appropriation for each purpose are as follows:

627.5 <u>(a) SOS Mental Health</u>	<u>115,738,000</u>	<u>115,738,000</u>
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627.6 **Dedicated Receipts Available.** Of the
 627.7 revenue received under Minnesota Statutes,
 627.8 section 246.18, subdivision 8, paragraph
 627.9 (a), \$1,000,000 each year is available for
 627.10 the purposes of paragraph (b), clause (1),
 627.11 of that subdivision, \$1,000,000 each year
 627.12 is available to transfer to the adult mental
 627.13 health budget activity for the purposes of
 627.14 paragraph (b), clause (2), of that subdivision,
 627.15 and up to \$2,713,000 each year is available
 627.16 for the purposes of paragraph (b), clause (3),
 627.17 of that subdivision.

627.18 <u>(b) SOS MN Security Hospital</u>	<u>69,582,000</u>	<u>69,582,000</u>
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627.19 <u>Subd. 8. Sex Offender Program</u>	<u>76,769,000</u>	<u>79,745,000</u>
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627.20 **Transfer Authority Related to Minnesota**
 627.21 **Sex Offender Program.** Money
 627.22 appropriated for the Minnesota sex offender
 627.23 program may be transferred between fiscal
 627.24 years of the biennium with the approval of the
 627.25 commissioner of management and budget.

627.26 <u>Subd. 9. Technical Activities</u>	<u>80,440,000</u>	<u>80,829,000</u>
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627.27 This appropriation is from the federal TANF
 627.28 fund.

627.29 **Base Adjustment.** The federal TANF fund
 627.30 base is increased by \$278,000 in fiscal year
 627.31 2016 and increased by \$651,000 in fiscal
 627.32 year 2017.

627.33 **Subd. 10. C.A.R.E.**

628.1 (a) Notwithstanding Minnesota Statutes,
 628.2 section 254B.06, subdivision 1, \$2,200,000
 628.3 is transferred from the consolidated chemical
 628.4 dependency treatment fund administrative
 628.5 account in the special revenue fund and
 628.6 deposited into the enterprise fund for the
 628.7 Community Addiction Recovery Enterprise
 628.8 in fiscal year 2013.

628.9 (b) Notwithstanding Minnesota Statutes,
 628.10 section 245.037, \$1,000,000 must be
 628.11 transferred from the dedicated services
 628.12 - Lease Income Brainerd account in the
 628.13 special revenue fund and deposited into the
 628.14 enterprise fund for the Community Addiction
 628.15 Recovery Enterprise in fiscal year 2013.

628.16 (c) Paragraphs (a) and (b) are effective the
 628.17 day following final enactment.

628.18 **Sec. 3. COMMISSIONER OF HEALTH**

628.19 Subdivision 1. **Total Appropriation** **\$ 169,326,000 \$ 165,531,000**

628.20	<u>Appropriations by Fund</u>		
628.21		<u>2014</u>	<u>2015</u>
628.22	<u>General</u>	<u>79,476,000</u>	<u>74,256,000</u>
628.23	<u>State Government</u>		
628.24	<u>Special Revenue</u>	<u>48,094,000</u>	<u>50,119,000</u>
628.25	<u>Health Care Access</u>	<u>29,743,000</u>	<u>29,143,000</u>
628.26	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>
628.27	<u>Special Revenue</u>	<u>300,000</u>	<u>300,000</u>

628.28 The amounts that may be spent for each
 628.29 purpose are specified in the following
 628.30 subdivisions.

628.31 **Subd. 2. Health Improvement**

628.32	<u>Appropriations by Fund</u>		
628.33	<u>General</u>	<u>52,864,000</u>	<u>47,644,000</u>
628.34	<u>State Government</u>		
628.35	<u>Special Revenue</u>	<u>1,033,000</u>	<u>1,033,000</u>

629.1	<u>Health Care Access</u>	<u>17,500,000</u>	<u>17,500,000</u>
629.2	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

629.3 Notwithstanding the cancellation requirement
 629.4 in Minnesota Statutes, section 256J.02,
 629.5 subdivision 6, TANF funds awarded under
 629.6 Minnesota Statutes, section 145.928, during
 629.7 fiscal year 2013 to grantees determined
 629.8 during the application process to have limited
 629.9 financial capacity, are available until June
 629.10 30, 2014.

629.11 **Statewide Health Improvement Program.**
 629.12 \$17,500,000 in fiscal year 2014 and
 629.13 \$17,500,000 in fiscal year 2015 is from the
 629.14 health care access fund for the statewide
 629.15 health improvement program under
 629.16 Minnesota Statutes, section 145.986. Funds
 629.17 appropriated under this paragraph are
 629.18 available until expended. No more than 16
 629.19 percent of the SHIP budget may be used
 629.20 for administration, technical assistance,
 629.21 and state-level evaluation costs. The
 629.22 commissioner shall incorporate strategies
 629.23 for improving health outcomes and reducing
 629.24 health care costs in populations over age 60
 629.25 to the menu of statewide health improvement
 629.26 program strategies.

629.27 **Statewide Cancer Surveillance System. Of**
 629.28 the general fund appropriation, \$350,000 in
 629.29 fiscal year 2014 and \$350,000 in fiscal year
 629.30 2015 is to develop and implement a new
 629.31 cancer reporting system under Minnesota
 629.32 Statutes, sections 144.671 to 144.69. Any
 629.33 information technology development or
 629.34 support costs necessary for the cancer
 629.35 surveillance system must be incorporated

630.1 into the agency's service level agreement and
630.2 paid to the Office of Enterprise Technology.

630.3 **Minnesota Poison Information Center.**
630.4 \$500,000 in fiscal year 2014 and \$500,000
630.5 in fiscal year 2015 from the general fund
630.6 is for regional poison information centers
630.7 according to Minnesota Statutes, section
630.8 145.93.

630.9 **Support Services for Deaf and**
630.10 **Hard-of-Hearing.** (a) \$365,000 in fiscal
630.11 year 2014 and \$349,000 in fiscal year 2015
630.12 are for providing support services to families
630.13 as required under Minnesota Statutes, section
630.14 144.966, subdivision 3a.

630.15 (b) \$164,000 in fiscal year 2014 and \$156,000
630.16 in fiscal year 2015 are for home-based
630.17 education in American Sign Language for
630.18 families with children who are deaf or have
630.19 hearing loss, as required under Minnesota
630.20 Statutes, section 144.966, subdivision 3a.

630.21 **Reproductive Health Strategic Plan to**
630.22 **Reduce Health Disparities for Somali**
630.23 **Women.** To the extent funds are available
630.24 for fiscal years 2014 and 2015 for grants
630.25 provided pursuant to Minnesota Statutes,
630.26 section 145.928, the commissioner
630.27 shall provide a grant to a Somali-based
630.28 organization located in the metropolitan area
630.29 to develop a reproductive health strategic
630.30 plan to eliminate reproductive health
630.31 disparities for Somali women. The plan shall
630.32 develop initiatives to provide educational
630.33 and information resources to health care
630.34 providers, community organizations, and
630.35 Somali women to ensure effective interaction

631.1 with Somali culture and western medicine
631.2 and the delivery of appropriate health care
631.3 services, and the achievement of better health
631.4 outcomes for Somali women. The plan must
631.5 engage health care providers, the Somali
631.6 community, and Somali health-centered
631.7 organizations. The commissioner shall
631.8 submit a report to the chairs and ranking
631.9 minority members of the senate and house
631.10 committees with jurisdiction over health
631.11 policy on the strategic plan developed under
631.12 this grant for eliminating reproductive health
631.13 disparities for Somali women. The report
631.14 must be submitted by February 15, 2014.

631.15 **Sexual Violence Prevention.** Within
631.16 available appropriations, by January 15,
631.17 2015, the commissioner must report to the
631.18 legislature on its activities to prevent sexual
631.19 violence, including activities to promote
631.20 coordination of existing state programs and
631.21 services to achieve maximum impact on
631.22 addressing the root causes of sexual violence.

631.23 **Safe Harbor for Sexually Exploited**
631.24 **Youth.** (a) \$375,000 in fiscal year 2014 and
631.25 \$375,000 in fiscal year 2015 are for grants
631.26 to six regional navigators under Minnesota
631.27 Statutes, section 145.4717.

631.28 (b) \$100,000 in fiscal year 2014 and \$100,000
631.29 in fiscal year 2015 are for the director of
631.30 child sex trafficking prevention position.

631.31 (c) \$50,000 in fiscal year 2015 is for program
631.32 evaluation required under Minnesota
631.33 Statutes, section 145.4718.

631.34 **TANF Appropriations.** (1) \$1,156,000 of
631.35 the TANF funds is appropriated each year of

632.1 the biennium to the commissioner for family
632.2 planning grants under Minnesota Statutes,
632.3 section 145.925.

632.4 (2) \$3,579,000 of the TANF funds is
632.5 appropriated each year of the biennium to
632.6 the commissioner for home visiting and
632.7 nutritional services listed under Minnesota
632.8 Statutes, section 145.882, subdivision 7,
632.9 clauses (6) and (7). Funds must be distributed
632.10 to community health boards according to
632.11 Minnesota Statutes, section 145A.131,
632.12 subdivision 1.

632.13 (3) \$2,000,000 of the TANF funds is
632.14 appropriated each year of the biennium to
632.15 the commissioner for decreasing racial and
632.16 ethnic disparities in infant mortality rates
632.17 under Minnesota Statutes, section 145.928,
632.18 subdivision 7.

632.19 (4) \$4,978,000 of the TANF funds is
632.20 appropriated each year of the biennium to the
632.21 commissioner for the family home visiting
632.22 grant program according to Minnesota
632.23 Statutes, section 145A.17. \$4,000,000 of the
632.24 funding must be distributed to community
632.25 health boards according to Minnesota
632.26 Statutes, section 145A.131, subdivision 1.
632.27 \$978,000 of the funding must be distributed
632.28 to tribal governments based on Minnesota
632.29 Statutes, section 145A.14, subdivision 2a.

632.30 (5) The commissioner may use up to 6.23
632.31 percent of the funds appropriated each fiscal
632.32 year to conduct the ongoing evaluations
632.33 required under Minnesota Statutes, section
632.34 145A.17, subdivision 7, and training and
632.35 technical assistance as required under

633.1 Minnesota Statutes, section 145A.17,
 633.2 subdivisions 4 and 5.
 633.3 **TANF Carryforward.** Any unexpended
 633.4 balance of the TANF appropriation in the
 633.5 first year of the biennium does not cancel but
 633.6 is available for the second year.

633.7 **Subd. 3. Policy Quality and Compliance**

633.8	<u>Appropriations by Fund</u>		
633.9	<u>General</u>	<u>9,391,000</u>	<u>9,391,000</u>
633.10	<u>State Government</u>		
633.11	<u>Special Revenue</u>	<u>14,428,000</u>	<u>16,450,000</u>
633.12	<u>Health Care Access</u>	<u>12,243,000</u>	<u>11,643,000</u>

633.13 The health care access fund appropriation
 633.14 includes the base appropriation for health
 633.15 care homes activities.

633.16 **Base Level Adjustment.** The health care
 633.17 access base shall be increased by \$600,000
 633.18 in fiscal year 2016.

633.19 **Criminal Background Checks.** The state
 633.20 government special revenue fund base for
 633.21 fiscal year 2017 includes \$111,000 for the
 633.22 implementation of criminal background
 633.23 checks for occupational therapy practitioners,
 633.24 speech-language pathologists, audiologists,
 633.25 and hearing aid dispensers, if the Sunset
 633.26 Advisory Commission under Minnesota
 633.27 Statutes, section 3D.03, is repealed before
 633.28 June 30, 2014.

633.29 **Subd. 4. Health Protection**

633.30	<u>Appropriations by Fund</u>		
633.31	<u>General</u>	<u>9,201,000</u>	<u>9,201,000</u>
633.32	<u>State Government</u>		
633.33	<u>Special Revenue</u>	<u>32,633,000</u>	<u>32,636,000</u>
633.34	<u>Special Revenue</u>	<u>300,000</u>	<u>300,000</u>

634.1 **Infectious Disease Laboratory.** Of the
 634.2 general fund appropriation, \$200,000 in
 634.3 fiscal year 2014 and \$200,000 in fiscal year
 634.4 2015 are to monitor infectious disease trends
 634.5 and investigate infectious disease outbreaks.

634.6 **Surveillance for Elevated Blood Lead**
 634.7 **Levels.** Of the general fund appropriation,
 634.8 \$100,000 in fiscal year 2014 and \$100,000
 634.9 in fiscal year 2015 are for the blood lead
 634.10 surveillance system under Minnesota
 634.11 Statutes, section 144.9502.

634.12 **Base Level Adjustment.** The state
 634.13 government special revenue base is increased
 634.14 by \$6,000 in fiscal year 2016 and by \$13,000
 634.15 in fiscal year 2017.

634.16 **Subd. 5. Administrative Support Services** 8,020,000 8,020,000

634.17 The general fund appropriation includes the
 634.18 base appropriation for the Office of the State
 634.19 Epidemiologist.

634.20 **Regional Support for Local Public Health**
 634.21 **Departments.** \$350,000 in fiscal year
 634.22 2014 and \$350,000 in fiscal year 2015 is
 634.23 for regional staff who provide specialized
 634.24 expertise to local public health departments.

634.25 **Sec. 4. HEALTH-RELATED BOARDS**

634.26 **Subdivision 1. Total Appropriation** \$ 20,040,000 \$ 18,446,000

634.27 This appropriation is from the state
 634.28 government special revenue fund.

634.29 The amounts that may be spent for each
 634.30 purpose are specified in the following
 634.31 subdivisions.

634.32 **Subd. 2. Board of Chiropractic Examiners** 508,000 490,000

635.1	<u>This appropriation includes \$10,000</u>		
635.2	<u>for information technology hardware</u>		
635.3	<u>to streamline board operations. This</u>		
635.4	<u>is a onetime appropriation. \$15,000 is</u>		
635.5	<u>for a LEAN evaluation. This is a onetime</u>		
635.6	<u>appropriation. \$2,000 in fiscal years 2014 and</u>		
635.7	<u>2015 is for rental of additional storage space.</u>		
635.8	Subd. 3. <u>Board of Dentistry</u>	<u>2,059,000</u>	<u>2,056,000</u>
635.9	<u>This appropriation includes \$843,000 in fiscal</u>		
635.10	<u>year 2014 and \$837,000 in fiscal year 2015</u>		
635.11	<u>for the health professional services program.</u>		
635.12	<u>\$15,000 in fiscal year 2014 is for repairs,</u>		
635.13	<u>maintenance, furnishings, and ergonomic</u>		
635.14	<u>upgrades. This is a onetime appropriation.</u>		
635.15	<u>\$35,000 in fiscal years 2014 and 2015 is for</u>		
635.16	<u>additional staff to implement new regulatory</u>		
635.17	<u>activity. \$20,000 in fiscal years 2014 and</u>		
635.18	<u>2015 is for database upgrades for regulatory</u>		
635.19	<u>and licensing activities. \$10,000 in fiscal</u>		
635.20	<u>years 2014 and 2015 is for professional and</u>		
635.21	<u>technical contracts for expert consultants</u>		
635.22	<u>to review complex complaints, advise on</u>		
635.23	<u>specialty dentistry areas, and to serve as</u>		
635.24	<u>expert witnesses in contested case matters.</u>		
635.25	Subd. 4. <u>Board of Dietetic and Nutrition</u>		
635.26	<u>Practice</u>	<u>111,000</u>	<u>111,000</u>
635.27	Subd. 5. <u>Board of Marriage and Family</u>		
635.28	<u>Therapy</u>	<u>254,000</u>	<u>226,000</u>
635.29	<u>This appropriation includes \$25,000 in fiscal</u>		
635.30	<u>year 2014 for rulemaking. This is a onetime</u>		
635.31	<u>appropriation. \$31,000 in fiscal year 2014</u>		
635.32	<u>and \$27,000 in fiscal year 2015 are for</u>		
635.33	<u>additional staff to improve licensing and</u>		
635.34	<u>licensing renewal activities. \$30,000 in fiscal</u>		
635.35	<u>year 2014 and \$31,000 in fiscal year 2015</u>		

636.1 are to increase the executive director to a
 636.2 full-time position.

636.3 The remaining balance of the state
 636.4 government special revenue fund
 636.5 appropriation in Laws 2011, First Special
 636.6 Session chapter 9, article 10, section 8,
 636.7 subdivision 5, for Board of Marriage and
 636.8 Family Therapy rulemaking, estimated to
 636.9 be \$25,000, is canceled. This paragraph is
 636.10 effective the day following final enactment.

636.11	<u>Subd. 6. Board of Medical Practice</u>	<u>3,867,000</u>	<u>3,867,000</u>
636.12	<u>Subd. 7. Board of Nursing</u>	<u>3,637,000</u>	<u>3,637,000</u>
636.13	<u>Subd. 8. Board of Nursing Home</u>		
636.14	<u>Administrators</u>	<u>3,742,000</u>	<u>2,252,000</u>

636.15 **Administrative Services Unit - Operating**
 636.16 **Costs.** Of this appropriation, \$676,000
 636.17 in fiscal year 2014 and \$626,000 in
 636.18 fiscal year 2015 are for operating costs
 636.19 of the administrative services unit. The
 636.20 administrative services unit may receive
 636.21 and expend reimbursements for services
 636.22 performed by other agencies.

636.23 **Administrative Services Unit - Volunteer**
 636.24 **Health Care Provider Program.** Of this
 636.25 appropriation, \$150,000 in fiscal year 2014
 636.26 and \$150,000 in fiscal year 2015 are to pay
 636.27 for medical professional liability coverage
 636.28 required under Minnesota Statutes, section
 636.29 214.40.

636.30 **Administrative Services Unit - Contested**
 636.31 **Cases and Other Legal Proceedings.** Of
 636.32 this appropriation, \$200,000 in fiscal year
 636.33 2014 and \$200,000 in fiscal year 2015 are
 636.34 for costs of contested case hearings and other

637.1 unanticipated costs of legal proceedings
637.2 involving health-related boards funded
637.3 under this section. Upon certification of a
637.4 health-related board to the administrative
637.5 services unit that the costs will be incurred
637.6 and that there is insufficient money available
637.7 to pay for the costs out of money currently
637.8 available to that board, the administrative
637.9 services unit is authorized to transfer money
637.10 from this appropriation to the board for
637.11 payment of those costs with the approval
637.12 of the commissioner of management and
637.13 budget.

637.14 This appropriation includes \$44,000 in
637.15 fiscal year 2014 for rulemaking. This is
637.16 a onetime appropriation. \$1,441,000 in
637.17 fiscal year 2014 and \$420,000 in fiscal year
637.18 2015 are for the development of a shared
637.19 disciplinary, regulatory, licensing, and
637.20 information management system. \$391,000
637.21 in fiscal year 2014 is a onetime appropriation
637.22 for retirement costs in the health-related
637.23 boards. This funding may be transferred to
637.24 the health boards incurring retirement costs.
637.25 These funds are available either year of the
637.26 biennium.

637.27 This appropriation includes \$16,000 in fiscal
637.28 years 2014 and 2015 for evening security,
637.29 \$2,000 in fiscal years 2014 and 2015 for a
637.30 state vehicle lease, and \$18,000 in fiscal
637.31 years 2014 and 2015 for shared office space
637.32 and administrative support. \$205,000 in
637.33 fiscal year 2014 and \$221,000 in fiscal year
637.34 2015 are for shared information technology
637.35 services, equipment, and maintenance.

638.1 The remaining balance of the state
 638.2 government special revenue fund
 638.3 appropriation in Laws 2011, First Special
 638.4 Session chapter 9, article 10, section 8,
 638.5 subdivision 8, for Board of Nursing Home
 638.6 Administrators rulemaking, estimated to
 638.7 be \$44,000, is canceled, and the remaining
 638.8 balance of the state government special
 638.9 revenue fund appropriation in Laws 2011,
 638.10 First Special Session chapter 9, article 10,
 638.11 section 8, subdivision 8, for electronic
 638.12 licensing system adaptors, estimated to be
 638.13 \$761,000, and for the development and
 638.14 implementation of a disciplinary, regulatory,
 638.15 licensing, and information management
 638.16 system, estimated to be \$1,100,000, are
 638.17 canceled. This paragraph is effective the day
 638.18 following final enactment.

638.19 **Base Adjustment.** The base is decreased by
 638.20 \$370,000 in fiscal years 2016 and 2017.

638.21	<u>Subd. 9. Board of Optometry</u>	<u>107,000</u>	<u>107,000</u>
638.22	<u>Subd. 10. Board of Pharmacy</u>	<u>2,555,000</u>	<u>2,555,000</u>

638.23 **Prescription Electronic Reporting.** Of
 638.24 this appropriation, \$356,000 in fiscal year
 638.25 2014 and \$356,000 in fiscal year 2015 from
 638.26 the state government special revenue fund
 638.27 are to the board to operate the prescription
 638.28 monitoring program in Minnesota Statutes,
 638.29 section 152.126.

638.30	<u>Subd. 11. Board of Physical Therapy</u>	<u>390,000</u>	<u>346,000</u>
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638.31 This appropriation includes \$44,000 in fiscal
 638.32 year 2014 for rulemaking. This is a onetime
 638.33 appropriation.

639.1	<u>The remaining balance of the state</u>		
639.2	<u>government special revenue fund</u>		
639.3	<u>appropriation in Laws 2011, First Special</u>		
639.4	<u>Session chapter 9, article 10, section 8,</u>		
639.5	<u>subdivision 11, for Board of Physical</u>		
639.6	<u>Therapy rulemaking, estimated to be</u>		
639.7	<u>\$44,000, is canceled. This paragraph is</u>		
639.8	<u>effective the day following final enactment.</u>		
639.9	<u>Subd. 12. Board of Podiatry</u>	<u>76,000</u>	<u>76,000</u>
639.10	<u>Subd. 13. Board of Psychology</u>	<u>892,000</u>	<u>892,000</u>
639.11	<u>This appropriation includes \$15,000 in</u>		
639.12	<u>fiscal years 2014 and 2015 for continuing</u>		
639.13	<u>educational programming. \$5,000 in fiscal</u>		
639.14	<u>years 2014 and 2015 are for a public</u>		
639.15	<u>education program. \$25,000 in fiscal years</u>		
639.16	<u>2014 and 2015 are for development of</u>		
639.17	<u>educational materials. This is a onetime</u>		
639.18	<u>appropriation.</u>		
639.19	<u>Base Adjustment. The base is decreased by</u>		
639.20	<u>\$45,000 in fiscal years 2016 and 2017.</u>		
639.21	<u>Subd. 14. Board of Social Work</u>	<u>1,109,000</u>	<u>1,110,000</u>
639.22	<u>This appropriation includes \$55,000 in fiscal</u>		
639.23	<u>year 2014 and \$56,000 in fiscal year 2015</u>		
639.24	<u>for additional staff to enhance the board's</u>		
639.25	<u>complaint resolution process.</u>		
639.26	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>262,000</u>	<u>256,000</u>
639.27	<u>This appropriation includes \$32,000 in fiscal</u>		
639.28	<u>year 2014 and \$26,000 in fiscal year 2015</u>		
639.29	<u>for additional staff to improve the board's</u>		
639.30	<u>complaint resolution process.</u>		
639.31	<u>Subd. 16. Board of Behavioral Health and</u>		
639.32	<u>Therapy</u>	<u>471,000</u>	<u>465,000</u>

640.1 This appropriation includes \$56,000 in fiscal
640.2 year 2014 and \$50,000 in fiscal year 2015 for
640.3 additional staff to enhance the licensing and
640.4 complaint resolution processes of the board.

640.5 **Sec. 5. EMERGENCY MEDICAL SERVICES**
640.6 **REGULATORY BOARD** \$ 2,741,000 \$ 2,741,000

640.7 **Regional Grants.** \$585,000 in fiscal year
640.8 2014 and \$585,000 in fiscal year 2015 are
640.9 for regional emergency medical services
640.10 programs, to be distributed equally to the
640.11 eight emergency medical service regions.

640.12 **Cooper/Sams Volunteer Ambulance**
640.13 **Program.** \$700,000 in fiscal year 2014 and
640.14 \$700,000 in fiscal year 2015 are for the
640.15 Cooper/Sams volunteer ambulance program
640.16 under Minnesota Statutes, section 144E.40.

640.17 (a) Of this amount, \$611,000 in fiscal year
640.18 2014 and \$611,000 in fiscal year 2015
640.19 are for the ambulance service personnel
640.20 longevity award and incentive program under
640.21 Minnesota Statutes, section 144E.40.

640.22 (b) Of this amount, \$89,000 in fiscal year
640.23 2014 and \$89,000 in fiscal year 2015 are
640.24 for the operations of the ambulance service
640.25 personnel longevity award and incentive
640.26 program under Minnesota Statutes, section
640.27 144E.40.

640.28 **Ambulance Training Grant.** \$361,000 in
640.29 fiscal year 2014 and \$361,000 in fiscal year
640.30 2015 are for training grants.

640.31 **EMSRB Board Operations.** \$1,095,000 in
640.32 fiscal year 2014 and \$1,095,000 in fiscal year
640.33 2015 are for operations.

641.1	Sec. 6. <u>COUNCIL ON DISABILITY</u>	\$	<u>614,000</u>	\$	<u>614,000</u>
641.2	Sec. 7. <u>OMBUDSMAN FOR MENTAL</u>				
641.3	<u>HEALTH AND DEVELOPMENTAL</u>				
641.4	<u>DISABILITIES</u>	\$	<u>1,654,000</u>	\$	<u>1,654,000</u>
641.5	Sec. 8. <u>OMBUDSPERSON FOR FAMILIES</u>	\$	<u>333,000</u>	\$	<u>334,000</u>

641.6 Sec. 9. Minnesota Statutes 2012, section 256.01, subdivision 34, is amended to read:

641.7 Subd. 34. **Federal administrative reimbursement dedicated.** Federal
 641.8 administrative reimbursement resulting from the following activities is appropriated to the
 641.9 commissioner for the designated purposes:

- 641.10 (1) reimbursement for the Minnesota senior health options project; ~~and~~
 641.11 (2) reimbursement related to prior authorization and inpatient admission certification
 641.12 by a professional review organization. A portion of these funds must be used for activities
 641.13 to decrease unnecessary pharmaceutical costs in medical assistance; and
 641.14 (3) reimbursement resulting from the federal child support grant expenditures
 641.15 authorized under United States Code, title 42, section 1315.

641.16 Sec. 10. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
 641.17 to read:

641.18 Subd. 35. **Federal reimbursement for privatized adoption grants.** Federal
 641.19 reimbursement for privatized adoption grant and foster care recruitment grant expenditures
 641.20 is appropriated to the commissioner for adoption grants and foster care and adoption
 641.21 administrative purposes.

641.22 Sec. 11. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
 641.23 to read:

641.24 Subd. 36. **DHS receipt center accounting.** The commissioner may transfer
 641.25 appropriations to, and account for DHS receipt center operations in, the special revenue
 641.26 fund.

641.27 Sec. 12. **APPROPRIATION ADJUSTMENTS.**

641.28 (a) The general fund appropriation in section 2, subdivision 5, paragraph (g),
 641.29 includes up to \$53,391,000 in fiscal year 2014; \$216,637,000 in fiscal year 2015;
 641.30 \$261,660,000 in fiscal year 2016; and \$279,984,000 in fiscal year 2017, for medical
 641.31 assistance eligibility and administration changes related to:

642.1 (1) eligibility for children age two to 18 with income up to 275 percent of the federal
642.2 poverty guidelines;

642.3 (2) eligibility for pregnant women with income up to 275 percent of the federal
642.4 poverty guidelines;

642.5 (3) Affordable Care Act enrollment and renewal processes, including elimination
642.6 of six-month renewals, ex parte eligibility reviews, preprinted renewal forms, changes
642.7 in verification requirements, and other changes in the eligibility determination and
642.8 enrollment and renewal process;

642.9 (4) automatic eligibility for children who turn 18 in foster care until they reach age 26;

642.10 (5) eligibility related to spousal impoverishment provisions for waiver recipients; and

642.11 (6) presumptive eligibility determinations by hospitals.

642.12 (b) The commissioner of human services shall determine the difference between the
642.13 actual or forecasted costs to the medical assistance program attributable to the program
642.14 changes in paragraph (a), clauses (1) to (6), and the costs of paragraph (a), clauses (1) to
642.15 (6), that were estimated during the 2013 legislative session based on data from the 2013
642.16 February forecast. The costs in this paragraph must be calculated between January 1,
642.17 2014, and June 30, 2017.

642.18 (c) For each fiscal year from 2014 to 2017, the commissioner of human services
642.19 shall certify the actual or forecasted cost differences to the medical assistance program
642.20 determined under paragraph (b), and report the difference in costs to the commissioner of
642.21 management and budget at least four weeks prior to a forecast under Minnesota Statutes,
642.22 section 16A.103. No later than three weeks before the release of the forecast under
642.23 Minnesota Statutes, section 16A.103, the commissioner of management and budget shall
642.24 reduce the health care access fund appropriation in section 2, subdivision 5, paragraph (g),
642.25 by the cumulative difference in costs determined in paragraph (b). If for any fiscal year,
642.26 the amount of the cumulative cost differences determined under paragraph (b) is positive,
642.27 no adjustment shall be made to the health care access fund appropriation. If for any fiscal
642.28 year, the amount of the cumulative cost differences determined under paragraph (b) is less
642.29 than the original appropriation, the appropriation for that fiscal year is zero.

642.30 (d) This section expires on January 1, 2018.

642.31 **Sec. 13. TRANSFERS.**

642.32 Subdivision 1. **Grants.** The commissioner of human services, with the approval of
642.33 the commissioner of management and budget, may transfer unencumbered appropriation
642.34 balances for the biennium ending June 30, 2015, within fiscal years among the MFIP,
642.35 general assistance, general assistance medical care under Minnesota Statutes 2009

643.1 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP
643.2 child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental
643.3 aid, group residential housing programs, the entitlement portion of the chemical
643.4 dependency consolidated treatment fund, and between fiscal years of the biennium. The
643.5 commissioner shall inform the chairs and ranking minority members of the senate Health
643.6 and Human Services Finance Division and the house of representatives Health and Human
643.7 Services Finance Committee quarterly about transfers made under this provision.

643.8 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
643.9 money may be transferred within the Departments of Human Services and Health as the
643.10 commissioners consider necessary, with the advance approval of the commissioner of
643.11 management and budget. The commissioner shall inform the chairs and ranking minority
643.12 members of the senate Health and Human Services Finance Division and the house of
643.13 representatives Health and Human Services Finance Committee quarterly about transfers
643.14 made under this provision.

643.15 Sec. 14. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

643.16 The commissioners of health and human services shall not use indirect cost
643.17 allocations to pay for the operational costs of any program for which they are responsible.

643.18 Sec. 15. **EXPIRATION OF UNCODIFIED LANGUAGE.**

643.19 All uncodified language contained in this article expires on June 30, 2015, unless a
643.20 different expiration date is explicit.

643.21 Sec. 16. **EFFECTIVE DATE.**

643.22 This article is effective July 1, 2013, unless a different effective date is specified.

643.23 **ARTICLE 15**

643.24 **REFORM 2020 CONTINGENT APPROPRIATIONS**

643.25 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

643.26 The sums shown in the columns marked "Appropriations" are appropriated to the
643.27 agencies and for the purposes specified in this article. The appropriations are from the
643.28 general fund, or another named fund, and are available for the fiscal years indicated
643.29 for each purpose. The figures "2014" and "2015" used in this article mean that the
643.30 appropriations listed under them are available for the fiscal year ending June 30, 2014, or
643.31 June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal
643.32 year 2015. "The biennium" is fiscal years 2014 and 2015.

644.1 644.2 644.3 644.4	<u>APPROPRIATIONS</u> <u>Available for the Year</u> <u>Ending June 30</u>	<u>2014</u>	<u>2015</u>
644.5	Sec. 2. <u>COMMISSIONER OF HUMAN</u>		
644.6	<u>SERVICES</u>		
644.7	<u>Subdivision 1. Total Appropriation</u>	\$ <u>2,144,000</u>	\$ <u>214,000</u>
644.8	<u>Subd. 2. Central Office</u>		
644.9	<u>The amounts that may be spent from this</u>		
644.10	<u>appropriation for each purpose are as follows:</u>		
644.11	<u>(a) Operations</u>	<u>2,909,000</u>	<u>8,957,000</u>
644.12	<u>Base Adjustment.</u> <u>The general fund base is</u>		
644.13	<u>decreased by \$8,916,000 in fiscal year 2016</u>		
644.14	<u>and \$8,916,000 in fiscal year 2017.</u>		
644.15	<u>(b) Children and Families</u>	<u>109,000</u>	<u>206,000</u>
644.16	<u>(c) Continuing Care</u>	<u>2,849,000</u>	<u>3,574,000</u>
644.17	<u>Base Adjustment.</u> <u>The general fund base is</u>		
644.18	<u>decreased by \$2,000 in fiscal year 2016 and</u>		
644.19	<u>by \$27,000 in fiscal year 2017.</u>		
644.20	<u>(d) Group Residential Housing</u>	<u>(1,166,000)</u>	<u>(8,602,000)</u>
644.21	<u>(e) Medical Assistance</u>	<u>(3,950,000)</u>	<u>(6,420,000)</u>
644.22	<u>(f) Alternative Care</u>	<u>(7,386,000)</u>	<u>(6,851,000)</u>
644.23	<u>(g) Child and Community Service Grants</u>	<u>3,000,000</u>	<u>3,000,000</u>
644.24	<u>(h) Aging and Adult Services Grants</u>	<u>5,365,000</u>	<u>5,936,000</u>
644.25	<u>Gaps Analysis.</u> <u>In fiscal year 2014, and</u>		
644.26	<u>in each even-numbered year thereafter,</u>		
644.27	<u>\$435,000 is appropriated to conduct an</u>		
644.28	<u>analysis of gaps in long-term care services</u>		
644.29	<u>under Minnesota Statutes, section 144A.351.</u>		
644.30	<u>This is a biennial appropriation. The base is</u>		
644.31	<u>increased by \$435,000 in fiscal year 2016.</u>		

645.1 Notwithstanding any contrary provisions in
645.2 this article, this provision does not expire.

645.3 **Base Adjustment.** The general fund base is
645.4 increased by \$498,000 in fiscal year 2016,
645.5 and decreased by \$124,000 in fiscal year
645.6 2017.

645.7 **(i) Disabilities Grants** 414,000 414,000

645.8 **Sec. 3. FEDERAL APPROVAL.**

645.9 (a) The implementation of this article and article 2 is contingent on federal approval.

645.10 (b) Upon full or partial approval of the waiver application, the commissioner of
645.11 human services shall submit to the commissioner of management and budget a plan for
645.12 implementing the provisions in this article that received federal approval as well as any
645.13 provisions that do not require federal approval. The plan must:

645.14 (1) include fiscal estimates that, with federal administrative reimbursement, do
645.15 not increase the general fund appropriations to the commissioner of human services in
645.16 fiscal years 2014 and 2015; and

645.17 (2) include a fiscal estimate for the systems modernization appropriation, which
645.18 cannot exceed \$11,598,000 for the biennium ending June 30, 2015.

645.19 (c) Upon approval by the commissioner of management and budget, the
645.20 commissioner of human services may implement the plan.

645.21 (d) The commissioner of management and budget must notify the chairs and ranking
645.22 minority members of the legislative committees with jurisdiction over health and human
645.23 services finance when the plan is approved. The plan must be made publicly available.

645.24 **Sec. 4. IMPLEMENTATION OF REFORM 2020 CONTINGENT PROVISIONS**
645.25 **AND ADJUSTMENTS TO APPROPRIATIONS AND PLANNING ESTIMATES.**

645.26 Upon approval of the plan in section 3, the commissioner of management and
645.27 budget shall make necessary adjustments to the appropriations in this article to reflect the
645.28 effective date of federal approval. The adjustments must include the nondedicated revenue
645.29 attributable to the provisions of this article and the related planning estimates for fiscal
645.30 years 2016 and 2017 must reflect the revised fiscal estimates attributable to the provisions
645.31 in this article. The revised appropriations for fiscal years 2014 and 2015 shall be included
645.32 in the forecast and must not increase the appropriations to the commissioner of human
645.33 services for fiscal years 2014 and 2015. If the adjustments to the planning estimates for
645.34 fiscal years 2016 and 2017 result in increased general fund expenditure estimates for

646.1 the commissioner of human services attributable to the provisions in this article, when
 646.2 compared to the planning estimates attributable to the provision in this article made in the
 646.3 February 2013 forecast, none of the provisions in this article shall be implemented.

646.4 **ARTICLE 16**

646.5 **HUMAN SERVICES FORECAST ADJUSTMENTS**

646.6 **Section 1. COMMISSIONER OF HUMAN**
 646.7 **SERVICES**

646.8 **Subdivision 1. Total Appropriation** **\$ (161,031,000)**

646.9 **Appropriations by Fund**

646.10 **2013**

646.11 **General Fund** **(158,668,000)**

646.12 **Health Care Access** **(7,179,000)**

646.13 **TANF** **4,816,000**

646.14 **Subd. 2. Forecasted Programs**

646.15 **(a) MFIP/DWP Grants**

646.16 **Appropriations by Fund**

646.17 **General Fund** **(8,211,000)**

646.18 **TANF** **4,399,000**

646.19 **(b) MFIP Child Care Assistance Grants** **10,113,000**

646.20 **(c) General Assistance Grants** **3,230,000**

646.21 **(d) Minnesota Supplemental Aid Grants** **(1,008,000)**

646.22 **(e) Group Residential Housing Grants** **(5,423,000)**

646.23 **(f) MinnesotaCare Grants** **(7,179,000)**

646.24 This appropriation is from the health care
 646.25 access fund.

646.26 **(g) Medical Assistance Grants** **(159,733,000)**

646.27 **(h) Alternative Care Grants** **-0-**

646.28 **(i) CD Entitlement Grants** **2,364,000**

646.29 **Subd. 3. Technical Activities** **417,000**

646.30 This appropriation is from the TANF fund.

646.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

647.1 **ARTICLE 17**

647.2 **NORTHSTAR CARE FOR CHILDREN**

647.3 Section 1. Minnesota Statutes 2012, section 256.0112, is amended by adding a
647.4 subdivision to read:

647.5 Subd. 10. **Contracts for child foster care services.** When local agencies negotiate
647.6 lead county contracts or purchase of service contracts for child foster care services, the
647.7 foster care maintenance payment made on behalf of the child shall follow the provisions of
647.8 Northstar Care for Children, chapter 256N. Foster care maintenance payments as defined
647.9 in section 256N.02, subdivision 15, represent costs for activities similar in nature to those
647.10 expected of parents and do not cover services rendered by the licensed or tribally approved
647.11 foster parent, facility, or administrative costs or fees. Payments made to foster parents
647.12 must follow the requirements of section 256N.26, subdivision 15. The legally responsible
647.13 agency must provide foster parents with the assessment and notice as specified in section
647.14 256N.24. The financially responsible agency is permitted to make additional payments for
647.15 specific services provided by the foster parents or facility, as permitted in section 256N.21,
647.16 subdivision 5. These additional payments are not considered foster care maintenance.

647.17 Sec. 2. Minnesota Statutes 2012, section 256.82, subdivision 2, is amended to read:

647.18 Subd. 2. **Foster care maintenance payments.** Beginning January 1, 1986, For the
647.19 purpose of foster care maintenance payments under title IV-E of the Social Security Act,
647.20 United States Code, title 42, sections 670 to 676, the county paying the maintenance
647.21 costs must be reimbursed for the costs from the federal money available for the purpose.
647.22 Beginning July 1, 1997, for the purposes of determining a child's eligibility under title
647.23 IV-E of the Social Security Act, the placing agency shall use AFDC requirements in
647.24 effect on July 16, 1996.

647.25 Sec. 3. Minnesota Statutes 2012, section 256.82, subdivision 3, is amended to read:

647.26 Subd. 3. **Setting foster care standard rates.** (a) The commissioner shall annually
647.27 establish minimum ~~standard maintenance~~ rates for foster care maintenance and including
647.28 supplemental difficulty of care payments for all children ~~in foster care~~ eligible for
647.29 Northstar Care for Children under chapter 256N.

647.30 (b) All children entering foster care on or after January 1, 2015, are eligible for
647.31 Northstar Care for Children under chapter 256N. Any increase in rates shall in no case
647.32 exceed three percent per annum.

647.33 (c) All children in foster care on December 31, 2014, must remain in the
647.34 pre-Northstar Care for Children foster care program under sections 256N.21, subdivision

648.1 6, and 260C.4411, subdivision 1. The rates for the pre-Northstar Care for Children foster
648.2 care program shall remain those in effect on January 1, 2013.

648.3 **Sec. 4. [256N.001] CITATION.**

648.4 Sections 256N.001 to 256N.28 may be cited as the "Northstar Care for Children Act."

648.5 Sections 256N.001 to 256N.28 establish Northstar Care for Children, which authorizes
648.6 certain benefits to support a child in need who is served by the Minnesota child welfare
648.7 system and who is the responsibility of the state, local county social service agencies, or
648.8 tribal social service agencies authorized under section 256.01, subdivision 14b, or are
648.9 otherwise eligible for federal adoption assistance. A child eligible under this chapter
648.10 has experienced a child welfare intervention that has resulted in the child being placed
648.11 away from the child's parents' care and is receiving foster care services consistent with
648.12 chapter 260B, 260C, or 260D, or is in the permanent care of relatives through a transfer of
648.13 permanent legal and physical custody, or in the permanent care of adoptive parents.

648.14 **Sec. 5. [256N.01] PUBLIC POLICY.**

648.15 (a) The legislature declares that the public policy of this state is to keep children safe
648.16 from harm and to ensure that when children suffer harmful or injurious experiences in
648.17 their lives, appropriate services are immediately available to keep them safe.

648.18 (b) Children do best in permanent, safe, nurturing homes where they can maintain
648.19 lifelong relationships with adults. Whenever safely possible, children are best served
648.20 when they can be nurtured and raised by their parents. Where services cannot be provided
648.21 to allow a child to remain safely at home, an out-of-home placement may be required.
648.22 When this occurs, reunification should be sought if it can be accomplished safely. When
648.23 it is not possible for parents to provide safety and permanency for their children, an
648.24 alternative permanent home must quickly be made available to the child, drawing from
648.25 kinship sources whenever possible.

648.26 (c) Minnesota understands the importance of having a comprehensive approach to
648.27 temporary out-of-home care and to permanent homes for children who cannot be reunited
648.28 with their families. It is critical that stable benefits be available to caregivers to ensure
648.29 that the child's needs can be met whether the child's situation and best interests call for
648.30 temporary foster care, transfer of permanent legal and physical custody to a relative, or
648.31 adoption. Northstar Care for Children focuses on the child's needs and strengths, and
648.32 the actual level of care provided by the caregiver, without consideration for the type of
648.33 placement setting. In this way caregivers are not faced with the burden of making specific
648.34 long-term decisions based upon competing financial incentives.

649.1 Sec. 6. **[256N.02] DEFINITIONS.**

649.2 Subdivision 1. **Scope.** For the purposes of sections 256N.001 to 256N.28, the terms
649.3 defined in this section have the meanings given them.

649.4 Subd. 2. **Adoption assistance.** "Adoption assistance" means medical coverage as
649.5 allowable under section 256B.055 and reimbursement of nonrecurring expenses associated
649.6 with adoption and may include financial support provided under agreement with the
649.7 financially responsible agency, the commissioner, and the parents of an adoptive child
649.8 whose special needs would otherwise make it difficult to place the child for adoption to
649.9 assist with the cost of caring for the child. Financial support may include a basic rate
649.10 payment and a supplemental difficulty of care rate.

649.11 Subd. 3. **Assessment.** "Assessment" means the process under section 256N.24 that
649.12 determines the benefits an eligible child may receive under section 256N.26.

649.13 Subd. 4. **At-risk child.** "At-risk child" means a child who does not have a
649.14 documented disability but who is at risk of developing a physical, mental, emotional, or
649.15 behavioral disability based on being related within the first or second degree to persons
649.16 who have an inheritable physical, mental, emotional, or behavioral disabling condition,
649.17 or from a background which has the potential to cause the child to develop a physical,
649.18 mental, emotional, or behavioral disability that the child is at risk of developing. The
649.19 disability must manifest during childhood.

649.20 Subd. 5. **Basic rate.** "Basic rate" means the maintenance payment made on behalf
649.21 of a child to support the costs caregivers incur to provide for a child's needs consistent with
649.22 the care parents customarily provide, including: food, clothing, shelter, daily supervision,
649.23 school supplies, and a child's personal incidentals. It also supports typical travel to the
649.24 child's home for visitation, and reasonable travel for the child to remain in the school in
649.25 which the child is enrolled at the time of placement.

649.26 Subd. 6. **Caregiver.** "Caregiver" means the foster parent or parents of a child in
649.27 foster care who meet the requirements of emergency relative placement, licensed foster
649.28 parents under chapter 245A, or foster parents licensed or approved by a tribe; the relative
649.29 custodian or custodians; or the adoptive parent or parents who have legally adopted a child.

649.30 Subd. 7. **Commissioner.** "Commissioner" means the commissioner of human
649.31 services or any employee of the Department of Human Services to whom the
649.32 commissioner has delegated appropriate authority.

649.33 Subd. 8. **County board.** "County board" means the board of county commissioners
649.34 in each county.

649.35 Subd. 9. **Disability.** "Disability" means a physical, mental, emotional, or behavioral
649.36 impairment that substantially limits one or more major life activities. Major life activities

650.1 include, but are not limited to: thinking, walking, hearing, breathing, working, seeing,
650.2 speaking, communicating, learning, developing and maintaining healthy relationships,
650.3 safely caring for oneself, and performing manual tasks. The nature, duration, and severity
650.4 of the impairment must be considered in determining if the limitation is substantial.

650.5 Subd. 10. **Financially responsible agency.** "Financially responsible agency" means
650.6 the agency that is financially responsible for a child. These agencies include both local
650.7 social service agencies under section 393.07 and tribal social service agencies authorized
650.8 in section 256.01, subdivision 14b, as part of the American Indian Child Welfare Initiative,
650.9 and Minnesota tribes who assume financial responsibility of children from other states.
650.10 Under Northstar Care for Children, the agency that is financially responsible at the time of
650.11 placement for foster care continues to be responsible under section 256N.27 for the local
650.12 share of any maintenance payments, even after finalization of the adoption of transfer of
650.13 permanent legal and physical custody of a child.

650.14 Subd. 11. **Guardianship assistance.** "Guardianship assistance" means medical
650.15 coverage, as allowable under section 256B.055, and reimbursement of nonrecurring
650.16 expenses associated with obtaining permanent legal and physical custody of a child, and
650.17 may include financial support provided under agreement with the financially responsible
650.18 agency, the commissioner, and the relative who has received a transfer of permanent legal
650.19 and physical custody of a child. Financial support may include a basic rate payment and a
650.20 supplemental difficulty of care rate to assist with the cost of caring for the child.

650.21 Subd. 12. **Human services board.** "Human services board" means a board
650.22 established under section 402.02; Laws 1974, chapter 293; or Laws 1976, chapter 340.

650.23 Subd. 13. **Initial assessment.** "Initial assessment" means the assessment conducted
650.24 within the first 30 days of a child's initial placement into foster care under section
650.25 256N.24, subdivisions 4 and 5.

650.26 Subd. 14. **Legally responsible agency.** "Legally responsible agency" means the
650.27 Minnesota agency that is assigned responsibility for placement, care, and supervision
650.28 of the child through a court order, voluntary placement agreement, or voluntary
650.29 relinquishment. These agencies include local social service agencies under section 393.07,
650.30 tribal social service agencies authorized in section 256.01, subdivision 14b, and Minnesota
650.31 tribes that assume court jurisdiction when legal responsibility is transferred to the tribal
650.32 social service agency through a Minnesota district court order. A Minnesota local social
650.33 service agency is otherwise financially responsible.

650.34 Subd. 15. **Maintenance payments.** "Maintenance payments" means the basic
650.35 rate plus any supplemental difficulty of care rate under Northstar Care for Children. It
650.36 specifically does not include the cost of initial clothing allowance, payment for social

651.1 services, or administrative payments to a child-placing agency. Payments are paid
651.2 consistent with section 256N.26.

651.3 Subd. 16. **Permanent legal and physical custody.** "Permanent legal and physical
651.4 custody" means a transfer of permanent legal and physical custody to a relative ordered by
651.5 a Minnesota juvenile court under section 260C.515, subdivision 4, or for a child under
651.6 jurisdiction of a tribal court, a judicial determination under a similar provision in tribal
651.7 code which means that a relative will assume the duty and authority to provide care,
651.8 control, and protection of a child who is residing in foster care, and to make decisions
651.9 regarding the child's education, health care, and general welfare until adulthood.

651.10 Subd. 17. **Reassessment.** "Reassessment" means an update of a previous assessment
651.11 through the process under section 256N.24 for a child who has been continuously eligible
651.12 for Northstar Care for Children, or when a child identified as an at-risk child (Level A)
651.13 under guardianship or adoption assistance has manifested the disability upon which
651.14 eligibility for the agreement was based according to section 256N.25, subdivision 3,
651.15 paragraph (b). A reassessment may be used to update an initial assessment, a special
651.16 assessment, or a previous reassessment.

651.17 Subd. 18. **Relative.** "Relative," as described in section 260C.007, subdivision 27,
651.18 means a person related to the child by blood, marriage, or adoption, or an individual who
651.19 is an important friend with whom the child has resided or had significant contact. For an
651.20 Indian child, relative includes members of the extended family as defined by the law or
651.21 custom of the Indian child's tribe or, in the absence of law or custom, nieces, nephews,
651.22 or first or second cousins, as provided in the Indian Child Welfare Act of 1978, United
651.23 States Code, title 25, section 1903.

651.24 Subd. 19. **Relative custodian.** "Relative custodian" means a person to whom
651.25 permanent legal and physical custody of a child has been transferred under section
651.26 260C.515, subdivision 4, or for a child under jurisdiction of a tribal court, a judicial
651.27 determination under a similar provision in tribal code, which means that a relative will
651.28 assume the duty and authority to provide care, control, and protection of a child who is
651.29 residing in foster care, and to make decisions regarding the child's education, health
651.30 care, and general welfare until adulthood.

651.31 Subd. 20. **Special assessment.** "Special assessment" means an assessment
651.32 performed under section 256N.24 that determines the benefits that an eligible child may
651.33 receive under section 256N.26 at the time when a special assessment is required. A
651.34 special assessment is used when a child's status within Northstar Care is shifted from a
651.35 pre-Northstar Care program into Northstar Care for Children and when the commissioner

652.1 determines that a special assessment is appropriate instead of assigning the transition child
652.2 to a level under section 256N.28.

652.3 Subd. 21. **Supplemental difficulty of care rate.** "Supplemental difficulty of care
652.4 rate" means the supplemental payment under section 256N.26, if any, as determined by
652.5 the financially responsible agency or the state, based upon an assessment under section
652.6 256N.24. The rate must support activities consistent with the care a parent provides a child
652.7 with special needs and not the equivalent of a purchased service. The rate must consider
652.8 the capacity and intensity of the activities associated with parenting duties provided in
652.9 the home to nurture the child, preserve the child's connections, and support the child's
652.10 functioning in the home and community.

652.11 Sec. 7. **[256N.20] NORTHSTAR CARE FOR CHILDREN; GENERALLY.**

652.12 Subdivision 1. **Eligibility.** A child is eligible for Northstar Care for Children if
652.13 the child is eligible for:

- 652.14 (1) foster care under section 256N.21;
652.15 (2) guardianship assistance under section 256N.22; or
652.16 (3) adoption assistance under section 256N.23.

652.17 Subd. 2. **Assessments.** Except as otherwise specified, a child eligible for Northstar
652.18 Care for Children shall receive an assessment under section 256N.24.

652.19 Subd. 3. **Agreements.** When a child is eligible for guardianship assistance or
652.20 adoption assistance, negotiations with caregivers and the development of a written,
652.21 binding agreement must be conducted under section 256N.25.

652.22 Subd. 4. **Benefits and payments.** A child eligible for Northstar Care for Children is
652.23 entitled to benefits specified in section 256N.26, based primarily on assessments under
652.24 section 256N.24, and, if appropriate, negotiations and agreements under section 256N.25.
652.25 Although paid to the caregiver, these benefits must be considered benefits of the child
652.26 rather than of the caregiver.

652.27 Subd. 5. **Federal, state, and local shares.** The cost of Northstar Care for Children
652.28 must be shared among the federal government, state, counties of financial responsibility,
652.29 and certain tribes as specified in section 256N.27.

652.30 Subd. 6. **Administration and appeals.** The commissioner and financially
652.31 responsible agency, or other agency designated by the commissioner, shall administer
652.32 Northstar Care for Children according to section 256N.28. The notification and fair
652.33 hearing process applicable to this chapter is defined in section 256N.28.

652.34 Subd. 7. **Transition.** A child in foster care, relative custody assistance, or adoption
652.35 assistance prior to January 1, 2015, who remains with the same caregivers continues

653.1 to receive benefits under programs preceding Northstar Care for Children, unless the
653.2 child moves to a new foster care placement, permanency is obtained for the child, or the
653.3 commissioner initiates transition of a child receiving pre-Northstar Care for Children
653.4 relative custody assistance, guardianship assistance, or adoption assistance under this
653.5 chapter. Provisions for the transition to Northstar Care for Children for certain children in
653.6 preceding programs are specified in section 256N.28, subdivisions 2 and 7. Additional
653.7 provisions for children in: foster care are specified in section 256N.21, subdivision
653.8 6; relative custody assistance under section 257.85 are specified in section 256N.22,
653.9 subdivision 12; and adoption assistance under chapter 259A are specified in section
653.10 256N.23, subdivision 13.

653.11 **Sec. 8. [256N.21] ELIGIBILITY FOR FOSTER CARE BENEFITS.**

653.12 **Subdivision 1. General eligibility requirements.** (a) A child is eligible for foster
653.13 care benefits under this section if the child meets the requirements of subdivision 2 on
653.14 or after January 1, 2015.

653.15 (b) The financially responsible agency shall make a title IV-E eligibility determination
653.16 for all foster children meeting the requirements of subdivision 2, provided the agency has
653.17 such authority under the state title IV-E plan. To be eligible for title IV-E foster care, a child
653.18 must also meet any additional criteria specified in section 472 of the Social Security Act.

653.19 (c) Except as provided under section 256N.26, subdivision 1 or 6, the foster care
653.20 benefit to the child under this section must be determined under sections 256N.24 and
653.21 256N.26 through an individual assessment. Information from this assessment must be
653.22 used to determine a potential future benefit under guardianship assistance or adoption
653.23 assistance, if needed.

653.24 (d) When a child is eligible for additional services, subdivisions 3 and 4 govern
653.25 the co-occurrence of program eligibility.

653.26 **Subd. 2. Placement in foster care.** To be eligible for foster care benefits under this
653.27 section, the child must be in placement away from the child's legal parent or guardian and
653.28 all of the following criteria must be met:

653.29 (1) the legally responsible agency must have placement authority and care
653.30 responsibility, including for a child 18 years old or older and under age 21, who maintains
653.31 eligibility for foster care consistent with section 260C.451;

653.32 (2) the legally responsible agency must have authority to place the child with a
653.33 voluntary placement agreement or a court order, consistent with sections 260B.198,
653.34 260C.001, 260D.01, or continued eligibility consistent with section 260C.451; and

654.1 (3) the child must be placed in an emergency relative placement under section
654.2 245A.035, a licensed foster family setting, foster residence setting, or treatment foster
654.3 care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, a family
654.4 foster home licensed or approved by a tribal agency or, for a child 18 years old or older
654.5 and under age 21, an unlicensed supervised independent living setting approved by the
654.6 agency responsible for the youth's care.

654.7 Subd. 3. **Minor parent.** A child who is a minor parent in placement with the minor
654.8 parent's child in the same home is eligible for foster care benefits under this section. The
654.9 foster care benefit is limited to the minor parent, unless the legally responsible agency has
654.10 separate legal authority for placement of the minor parent's child.

654.11 Subd. 4. **Foster children ages 18 up to 21 placed in an unlicensed supervised**
654.12 **independent living setting.** A foster child 18 years old or older and under age 21 who
654.13 maintains eligibility consistent with section 260C.451 and who is placed in an unlicensed
654.14 supervised independent living setting shall receive the level of benefit under section
654.15 256N.26.

654.16 Subd. 5. **Excluded activities.** The basic and supplemental difficulty of care
654.17 payment represents costs for activities similar in nature to those expected of parents,
654.18 and does not cover services rendered by the licensed or tribally approved foster parent,
654.19 facility, or administrative costs or fees. The financially responsible agency may pay an
654.20 additional fee for specific services provided by the licensed foster parent or facility. A
654.21 foster parent or residence setting must distinguish such a service from the daily care of the
654.22 child as assessed through the process under section 256N.24.

654.23 Subd. 6. **Transition from pre-Northstar Care for Children program.** (a) Section
654.24 256.82 establishes the pre-Northstar Care for Children foster care program for all children
654.25 residing in family foster care on December 31, 2014. Unless transitioned under paragraph
654.26 (b), a child in foster care with the same caregiver receives benefits under this pre-Northstar
654.27 Care for Children foster care program.

654.28 (b) Transition from the pre-Northstar Care for Children foster care program to
654.29 Northstar Care for Children takes place on or after January 1, 2015, when the child:

654.30 (1) moves to a different foster home or unlicensed supervised independent living
654.31 setting;

654.32 (2) has permanent legal and physical custody transferred and, if applicable, meets
654.33 eligibility requirements in section 256N.22;

654.34 (3) is adopted and, if applicable, meets eligibility requirements in section 256N.23; or

654.35 (4) re-enters foster care after reunification or a trial home visit.

655.1 (c) Upon becoming eligible, a foster child must be assessed according to section
655.2 256N.24 and then transitioned into Northstar Care for Children according to section
655.3 256N.28.

655.4 Sec. 9. **[256N.22] GUARDIANSHIP ASSISTANCE ELIGIBILITY.**

655.5 Subdivision 1. General eligibility requirements. (a) To be eligible for guardianship
655.6 assistance under this section, there must be a judicial determination under section
655.7 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to a
655.8 relative is in the child's best interest. For a child under jurisdiction of a tribal court, a
655.9 judicial determination under a similar provision in tribal code indicating that a relative
655.10 will assume the duty and authority to provide care, control, and protection of a child who
655.11 is residing in foster care, and to make decisions regarding the child's education, health
655.12 care, and general welfare until adulthood, and that this is in the child's best interest is
655.13 considered equivalent. Additionally, a child must:

655.14 (1) have been removed from the child's home pursuant to a voluntary placement
655.15 agreement or court order;

655.16 (2)(i) have resided in foster care for at least six consecutive months in the home
655.17 of the prospective relative custodian; or

655.18 (ii) have received an exemption from the requirement in item (i) from the court
655.19 based on a determination that:

655.20 (A) an expedited move to permanency is in the child's best interest;

655.21 (B) expedited permanency cannot be completed without provision of guardianship
655.22 assistance; and

655.23 (C) the prospective relative custodian is uniquely qualified to meet the child's needs
655.24 on a permanent basis;

655.25 (3) meet the agency determinations regarding permanency requirements in
655.26 subdivision 2;

655.27 (4) meet the applicable citizenship and immigration requirements in subdivision 3;

655.28 (5) have been consulted regarding the proposed transfer of permanent legal and
655.29 physical custody to a relative, if the child is at least 14 years of age or is expected to attain
655.30 14 years of age prior to the transfer of permanent legal and physical custody; and

655.31 (6) have a written, binding agreement under section 256N.25 among the caregiver or
655.32 caregivers, the financially responsible agency, and the commissioner established prior to
655.33 transfer of permanent legal and physical custody.

656.1 (b) In addition to the requirements in paragraph (a), the child's prospective relative
656.2 custodian or custodians must meet the applicable background study requirements in
656.3 subdivision 4.

656.4 (c) To be eligible for title IV-E guardianship assistance, a child must also meet any
656.5 additional criteria in section 473(d) of the Social Security Act. The sibling of a child
656.6 who meets the criteria for title IV-E guardianship assistance in section 473(d) of the
656.7 Social Security Act is eligible for title IV-E guardianship assistance if the child and
656.8 sibling are placed with the same prospective relative custodian or custodians, and the
656.9 legally responsible agency, relatives, and commissioner agree on the appropriateness of
656.10 the arrangement for the sibling. A child who meets all eligibility criteria except those
656.11 specific to title IV-E guardianship assistance is entitled to guardianship assistance paid
656.12 through funds other than title IV-E.

656.13 Subd. 2. **Agency determinations regarding permanency.** (a) To be eligible for
656.14 guardianship assistance, the legally responsible agency must complete the following
656.15 determinations regarding permanency for the child prior to the transfer of permanent
656.16 legal and physical custody:

656.17 (1) a determination that reunification and adoption are not appropriate permanency
656.18 options for the child; and

656.19 (2) a determination that the child demonstrates a strong attachment to the prospective
656.20 relative custodian and the prospective relative custodian has a strong commitment to
656.21 caring permanently for the child.

656.22 (b) The legally responsible agency shall document the determinations in paragraph
656.23 (a) and the supporting information for completing each determination in the case file and
656.24 make them available for review as requested by the financially responsible agency and the
656.25 commissioner during the guardianship assistance eligibility determination process.

656.26 Subd. 3. **Citizenship and immigration status.** A child must be a citizen of the
656.27 United States or otherwise be eligible for federal public benefits according to the Personal
656.28 Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order
656.29 to be eligible for guardianship assistance.

656.30 Subd. 4. **Background study.** (a) A background study under section 245C.33 must
656.31 be completed on each prospective relative custodian and any other adult residing in the
656.32 home of the prospective relative custodian. A background study on the prospective
656.33 relative custodian or adult residing in the household previously completed under section
656.34 245C.04 for the purposes of foster care licensure may be used for the purposes of this
656.35 section, provided that the background study is current at the time of the application for
656.36 guardianship assistance.

657.1 (b) If the background study reveals:
657.2 (1) a felony conviction at any time for:
657.3 (i) child abuse or neglect;
657.4 (ii) spousal abuse;
657.5 (iii) a crime against a child, including child pornography; or
657.6 (iv) a crime involving violence, including rape, sexual assault, or homicide, but not
657.7 including other physical assault or battery; or
657.8 (2) a felony conviction within the past five years for:
657.9 (i) physical assault;
657.10 (ii) battery; or
657.11 (iii) a drug-related offense;
657.12 the prospective relative custodian is prohibited from receiving guardianship assistance
657.13 on behalf of an otherwise eligible child.

657.14 Subd. 5. **Responsibility for determining guardianship assistance eligibility.** The
657.15 commissioner shall determine eligibility for:

657.16 (1) a child under the legal custody or responsibility of a Minnesota county social
657.17 service agency who would otherwise remain in foster care;
657.18 (2) a Minnesota child under tribal court jurisdiction who would otherwise remain
657.19 in foster care; and
657.20 (3) an Indian child being placed in Minnesota who meets title IV-E eligibility defined
657.21 in section 473(d) of the Social Security Act. The agency or entity assuming responsibility
657.22 for the child is responsible for the nonfederal share of the guardianship assistance payment.

657.23 Subd. 6. **Exclusions.** (a) A child with a guardianship assistance agreement under
657.24 Northstar Care for Children is not eligible for the Minnesota family investment program
657.25 child-only grant under chapter 256J.

657.26 (b) The commissioner shall not enter into a guardianship assistance agreement with:

657.27 (1) a child's biological parent;
657.28 (2) an individual assuming permanent legal and physical custody of a child or the
657.29 equivalent under tribal code without involvement of the child welfare system; or
657.30 (3) an individual assuming permanent legal and physical custody of a child who was
657.31 placed in Minnesota by another state or a tribe outside of Minnesota.

657.32 Subd. 7. **Guardianship assistance eligibility determination.** The financially
657.33 responsible agency shall prepare a guardianship assistance eligibility determination
657.34 for review and final approval by the commissioner. The eligibility determination must
657.35 be completed according to requirements and procedures and on forms prescribed by
657.36 the commissioner. Supporting documentation for the eligibility determination must be

658.1 provided to the commissioner. The financially responsible agency and the commissioner
658.2 must make every effort to establish a child's eligibility for title IV-E guardianship
658.3 assistance. A child who is determined to be eligible for guardianship assistance must
658.4 have a guardianship assistance agreement negotiated on the child's behalf according to
658.5 section 256N.25.

658.6 Subd. 8. **Termination of agreement.** (a) A guardianship assistance agreement must
658.7 be terminated in any of the following circumstances:

658.8 (1) the child has attained the age of 18, or up to age 21 when the child meets a
658.9 condition for extension in subdivision 11;

658.10 (2) the child has not attained the age of 18 years of age, but the commissioner
658.11 determines the relative custodian is no longer legally responsible for support of the child;

658.12 (3) the commissioner determines the relative custodian is no longer providing
658.13 financial support to the child up to age 21;

658.14 (4) the death of the child; or

658.15 (5) the relative custodian requests in writing termination of the guardianship
658.16 assistance agreement.

658.17 (b) A relative custodian is considered no longer legally responsible for support of
658.18 the child in any of the following circumstances:

658.19 (1) permanent legal and physical custody or guardianship of the child is transferred
658.20 to another individual;

658.21 (2) the death of the relative custodian under subdivision 9;

658.22 (3) the child enlists in the military;

658.23 (4) the child gets married; or

658.24 (5) the child is determined an emancipated minor through legal action.

658.25 Subd. 9. **Death of relative custodian or dissolution of custody.** The guardianship
658.26 assistance agreement ends upon death or dissolution of permanent legal and physical
658.27 custody of both relative custodians in the case of assignment of custody to two individuals,
658.28 or the sole relative custodian in the case of assignment of custody to one individual.
658.29 Guardianship assistance eligibility may be continued according to subdivision 10.

658.30 Subd. 10. **Assigning a child's guardianship assistance to a court-appointed**
658.31 **guardian or custodian.** (a) Guardianship assistance may be continued with the written
658.32 consent of the commissioner to an individual who is a guardian or custodian appointed by
658.33 a court for the child upon the death of both relative custodians in the case of assignment
658.34 of custody to two individuals, or the sole relative custodian in the case of assignment
658.35 of custody to one individual, unless the child is under the custody of a county, tribal,
658.36 or child-placing agency.

659.1 (b) Temporary assignment of guardianship assistance may be approved for a
659.2 maximum of six consecutive months from the death of the relative custodian or custodians
659.3 as provided in paragraph (a) and must adhere to the policies and procedures prescribed by
659.4 the commissioner. If a court has not appointed a permanent legal guardian or custodian
659.5 within six months, the guardianship assistance must terminate and must not be resumed.

659.6 (c) Upon assignment of assistance payments under this subdivision, assistance must
659.7 be provided from funds other than title IV-E.

659.8 Subd. 11. **Extension of guardianship assistance after age 18.** (a) Under the
659.9 circumstances outlined in paragraph (e), a child may qualify for extension of the
659.10 guardianship assistance agreement beyond the date the child attains age 18, up to the
659.11 date the child attains the age of 21.

659.12 (b) A request for extension of the guardianship assistance agreement must be
659.13 completed in writing and submitted, including all supporting documentation, by the
659.14 relative custodian to the commissioner at least 60 calendar days prior to the date that the
659.15 current agreement will terminate.

659.16 (c) A signed amendment to the current guardianship assistance agreement must be
659.17 fully executed between the relative custodian and the commissioner at least ten business
659.18 days prior to the termination of the current agreement. The request for extension and
659.19 the fully executed amendment must be made according to requirements and procedures
659.20 prescribed by the commissioner, including documentation of eligibility, and on forms
659.21 prescribed by the commissioner.

659.22 (d) If an agency is certifying a child for guardianship assistance and the child will
659.23 attain the age of 18 within 60 calendar days of submission, the request for extension must
659.24 be completed in writing and submitted, including all supporting documentation, with
659.25 the guardianship assistance application.

659.26 (e) A child who has attained the age of 16 prior to the effective date of the
659.27 guardianship assistance agreement is eligible for extension of the agreement up to the
659.28 date the child attains age 21 if the child:

659.29 (1) is dependent on the relative custodian for care and financial support; and

659.30 (2) meets at least one of the following conditions:

659.31 (i) is completing a secondary education program or a program leading to an
659.32 equivalent credential;

659.33 (ii) is enrolled in an institution which provides postsecondary or vocational education;

659.34 (iii) is participating in a program or activity designed to promote or remove barriers
659.35 to employment;

659.36 (iv) is employed for at least 80 hours per month; or

660.1 (v) is incapable of doing any of the activities described in items (i) to (iv) due to
660.2 a medical condition where incapability is supported by professional documentation
660.3 according to the requirements and procedures prescribed by the commissioner.

660.4 (f) A child who has not attained the age of 16 prior to the effective date of the
660.5 guardianship assistance agreement is eligible for extension of the guardianship assistance
660.6 agreement up to the date the child attains the age of 21 if the child is:

660.7 (1) dependent on the relative custodian for care and financial support; and

660.8 (2) possesses a physical or mental disability which impairs the capacity for
660.9 independent living and warrants continuation of financial assistance, as determined by
660.10 the commissioner.

660.11 Subd. 12. **Beginning guardianship assistance component of Northstar Care for**
660.12 **Children.** Effective November 27, 2014, a child who meets the eligibility criteria for
660.13 guardianship assistance in subdivision 1 may have a guardianship assistance agreement
660.14 negotiated on the child's behalf according to section 256N.25. The effective date of the
660.15 agreement must be January 1, 2015, or the date of the court order transferring permanent
660.16 legal and physical custody, whichever is later. Except as provided under section 256N.26,
660.17 subdivision 1, paragraph (c), the rate schedule for an agreement under this subdivision
660.18 is determined under section 256N.26 based on the age of the child on the date that the
660.19 prospective relative custodian signs the agreement.

660.20 Subd. 13. **Transition to guardianship assistance under Northstar Care for**
660.21 **Children.** The commissioner may execute guardianship assistance agreements for a child
660.22 with a relative custody agreement under section 257.85 executed on the child's behalf
660.23 on or before November 26, 2014, in accordance with the priorities outlined in section
660.24 256N.28, subdivision 7, paragraph (b). To facilitate transition into the guardianship
660.25 assistance program, the commissioner may waive any guardianship assistance eligibility
660.26 requirements for a child with a relative custody agreement under section 257.85 executed
660.27 on the child's behalf on or before November 26, 2014. Agreements negotiated under
660.28 this subdivision must be done according to the process outlined in section 256N.28,
660.29 subdivision 7. The maximum rate used in the negotiation process for an agreement under
660.30 this subdivision must be as outlined in section 256N.28, subdivision 7.

660.31 Sec. 10. **[256N.23] ADOPTION ASSISTANCE ELIGIBILITY.**

660.32 Subdivision 1. **General eligibility requirements.** (a) To be eligible for adoption
660.33 assistance under this section, a child must:

660.34 (1) be determined to be a child with special needs under subdivision 2;

660.35 (2) meet the applicable citizenship and immigration requirements in subdivision 3;

- 661.1 (3)(i) meet the criteria in section 473 of the Social Security Act; or
661.2 (ii) have had foster care payments paid on the child's behalf while in out-of-home
661.3 placement through the county or tribe and be either under the guardianship of the
661.4 commissioner or under the jurisdiction of a Minnesota tribe and adoption, according to
661.5 tribal law, is in the child's documented permanency plan; and
661.6 (4) have a written, binding agreement under section 256N.25 among the adoptive
661.7 parent, the financially responsible agency, or if there is no financially responsible agency,
661.8 the agency designated by the commissioner, and the commissioner established prior to
661.9 finalization of the adoption.
- 661.10 (b) In addition to the requirements in paragraph (a), an eligible child's adoptive parent
661.11 or parents must meet the applicable background study requirements in subdivision 4.
- 661.12 (c) A child who meets all eligibility criteria except those specific to title IV-E adoption
661.13 assistance shall receive adoption assistance paid through funds other than title IV-E.
- 661.14 **Subd. 2. Special needs determination.** (a) A child is considered a child with
661.15 special needs under this section if the requirements in paragraphs (b) to (g) are met.
- 661.16 (b) There must be a determination that the child must not or should not be returned
661.17 to the home of the child's parents as evidenced by:
- 661.18 (1) a court-ordered termination of parental rights;
661.19 (2) a petition to terminate parental rights;
661.20 (3) consent of parent to adoption accepted by the court under chapter 260C;
661.21 (4) in circumstances when tribal law permits the child to be adopted without a
661.22 termination of parental rights, a judicial determination by a tribal court indicating the valid
661.23 reason why the child cannot or should not return home;
- 661.24 (5) a voluntary relinquishment under section 259.25 or 259.47 or, if relinquishment
661.25 occurred in another state, the applicable laws in that state; or
661.26 (6) the death of the legal parent or parents if the child has two legal parents.
- 661.27 (c) There exists a specific factor or condition of which it is reasonable to conclude
661.28 that the child cannot be placed with adoptive parents without providing adoption
661.29 assistance as evidenced by:
- 661.30 (1) a determination by the Social Security Administration that the child meets all
661.31 medical or disability requirements of title XVI of the Social Security Act with respect to
661.32 eligibility for Supplemental Security Income benefits;
661.33 (2) a documented physical, mental, emotional, or behavioral disability not covered
661.34 under clause (1);
661.35 (3) a member of a sibling group being adopted at the same time by the same parent;

662.1 (4) an adoptive placement in the home of a parent who previously adopted a sibling
662.2 for whom they receive adoption assistance; or

662.3 (5) documentation that the child is an at-risk child.

662.4 (d) A reasonable but unsuccessful effort must have been made to place the child
662.5 with adoptive parents without providing adoption assistance as evidenced by:

662.6 (1) a documented search for an appropriate adoptive placement; or

662.7 (2) a determination by the commissioner that a search under clause (1) is not in the
662.8 best interests of the child.

662.9 (e) The requirement for a documented search for an appropriate adoptive placement
662.10 under paragraph (d), including the registration of the child with the state adoption
662.11 exchange and other recruitment methods under paragraph (f), must be waived if:

662.12 (1) the child is being adopted by a relative and it is determined by the child-placing
662.13 agency that adoption by the relative is in the best interests of the child;

662.14 (2) the child is being adopted by a foster parent with whom the child has developed
662.15 significant emotional ties while in the foster parent's care as a foster child and it is
662.16 determined by the child-placing agency that adoption by the foster parent is in the best
662.17 interests of the child; or

662.18 (3) the child is being adopted by a parent that previously adopted a sibling of the
662.19 child, and it is determined by the child-placing agency that adoption by this parent is
662.20 in the best interests of the child.

662.21 For an Indian child covered by the Indian Child Welfare Act, a waiver must not be
662.22 granted unless the child-placing agency has complied with the placement preferences
662.23 required by the Indian Child Welfare Act, United States Code, title 25, section 1915(a).

662.24 (f) To meet the requirement of a documented search for an appropriate adoptive
662.25 placement under paragraph (d), clause (1), the child-placing agency minimally must:

662.26 (1) conduct a relative search as required by section 260C.221 and give consideration
662.27 to placement with a relative, as required by section 260C.212, subdivision 2;

662.28 (2) comply with the placement preferences required by the Indian Child Welfare Act
662.29 when the Indian Child Welfare Act, United States Code, title 25, section 1915(a), applies;

662.30 (3) locate prospective adoptive families by registering the child on the state adoption
662.31 exchange, as required under section 259.75; and

662.32 (4) if registration with the state adoption exchange does not result in the identification
662.33 of an appropriate adoptive placement, the agency must employ additional recruitment
662.34 methods prescribed by the commissioner.

662.35 (g) Once the legally responsible agency has determined that placement with an
662.36 identified parent is in the child's best interests and made full written disclosure about the

663.1 child's social and medical history, the agency must ask the prospective adoptive parent if
663.2 the prospective adoptive parent is willing to adopt the child without receiving adoption
663.3 assistance under this section. If the identified parent is either unwilling or unable to
663.4 adopt the child without adoption assistance, the legally responsible agency must provide
663.5 documentation as prescribed by the commissioner to fulfill the requirement to make a
663.6 reasonable effort to place the child without adoption assistance. If the identified parent is
663.7 willing to adopt the child without adoption assistance, the parent must provide a written
663.8 statement to this effect to the legally responsible agency and the statement must be
663.9 maintained in the permanent adoption record of the legally responsible agency. For children
663.10 under guardianship of the commissioner, the legally responsible agency shall submit a copy
663.11 of this statement to the commissioner to be maintained in the permanent adoption record.

663.12 Subd. 3. **Citizenship and immigration status.** (a) A child must be a citizen of the
663.13 United States or otherwise eligible for federal public benefits according to the Personal
663.14 Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to
663.15 be eligible for the title IV-E adoption assistance program.

663.16 (b) A child must be a citizen of the United States or meet the qualified alien
663.17 requirements as defined in the Personal Responsibility and Work Opportunity
663.18 Reconciliation Act of 1996, as amended, in order to be eligible for adoption assistance
663.19 paid through funds other than title IV-E.

663.20 Subd. 4. **Background study.** A background study under section 259.41 must be
663.21 completed on each prospective adoptive parent. If the background study reveals:

663.22 (1) a felony conviction at any time for:

663.23 (i) child abuse or neglect;

663.24 (ii) spousal abuse;

663.25 (iii) a crime against a child, including child pornography; or

663.26 (iv) a crime involving violence, including rape, sexual assault, or homicide, but not

663.27 including other physical assault or battery; or

663.28 (2) a felony conviction within the past five years for:

663.29 (i) physical assault;

663.30 (ii) battery; or

663.31 (iii) a drug-related offense;

663.32 the adoptive parent is prohibited from receiving adoption assistance on behalf of an
663.33 otherwise eligible child.

663.34 Subd. 5. **Responsibility for determining adoption assistance eligibility.** The
663.35 commissioner must determine eligibility for:

664.1 (1) a child under the guardianship of the commissioner who would otherwise remain
664.2 in foster care;

664.3 (2) a child who is not under the guardianship of the commissioner who meets title
664.4 IV-E eligibility defined in section 473 of the Social Security Act and no state agency has
664.5 legal responsibility for placement and care of the child;

664.6 (3) a Minnesota child under tribal jurisdiction who would otherwise remain in foster
664.7 care; and

664.8 (4) an Indian child being placed in Minnesota who meets title IV-E eligibility defined
664.9 in section 473 of the Social Security Act. The agency or entity assuming responsibility for
664.10 the child is responsible for the nonfederal share of the adoption assistance payment.

664.11 Subd. 6. **Exclusions.** The commissioner must not enter into an adoption assistance
664.12 agreement with the following individuals:

664.13 (1) a child's biological parent or stepparent;

664.14 (2) a child's relative under section 260C.007, subdivision 27, with whom the child
664.15 resided immediately prior to child welfare involvement unless:

664.16 (i) the child was in the custody of a Minnesota county or tribal agency pursuant to
664.17 an order under chapter 260C or equivalent provisions of tribal code and the agency had
664.18 placement and care responsibility for permanency planning for the child; and

664.19 (ii) the child is under guardianship of the commissioner of human services according
664.20 to the requirements of section 260C.325, subdivision 1 or 3, or is a ward of a Minnesota
664.21 tribal court after termination of parental rights, suspension of parental rights, or a finding
664.22 by the tribal court that the child cannot safely return to the care of the parent;

664.23 (3) an individual adopting a child who is the subject of a direct adoptive placement
664.24 under section 259.47 or the equivalent in tribal code;

664.25 (4) a child's legal custodian or guardian who is now adopting the child; or

664.26 (5) an individual who is adopting a child who is not a citizen or resident of the
664.27 United States and was either adopted in another country or brought to the United States
664.28 for the purposes of adoption.

664.29 Subd. 7. **Adoption assistance eligibility determination.** (a) The financially
664.30 responsible agency shall prepare an adoption assistance eligibility determination for
664.31 review and final approval by the commissioner. When there is no financially responsible
664.32 agency, the adoption assistance eligibility determination must be completed by the
664.33 agency designated by the commissioner. The eligibility determination must be completed
664.34 according to requirements and procedures and on forms prescribed by the commissioner.
664.35 The financially responsible agency and the commissioner shall make every effort to
664.36 establish a child's eligibility for title IV-E adoption assistance. Documentation from a

665.1 qualified expert for the eligibility determination must be provided to the commissioner
665.2 to verify that a child meets the special needs criteria in subdivision 2. A child who
665.3 is determined to be eligible for adoption assistance must have an adoption assistance
665.4 agreement negotiated on the child's behalf according to section 256N.25.

665.5 (b) Documentation from a qualified expert of a disability is limited to evidence
665.6 deemed appropriate by the commissioner and must be submitted to the commissioner with
665.7 the eligibility determination. Examples of appropriate documentation include, but are not
665.8 limited to, medical records, psychological assessments, educational or early childhood
665.9 evaluations, court findings, and social and medical history.

665.10 (c) Documentation that the child is at risk of developing physical, mental, emotional,
665.11 or behavioral disabilities must be submitted according to policies and procedures
665.12 prescribed by the commissioner.

665.13 Subd. 8. **Termination of agreement.** (a) An adoption assistance agreement must
665.14 terminate in any of the following circumstances:

665.15 (1) the child has attained the age of 18, or up to age 21 when the child meets a
665.16 condition for extension in subdivision 12;

665.17 (2) the child has not attained the age of 18, but the commissioner determines the
665.18 adoptive parent is no longer legally responsible for support of the child;

665.19 (3) the commissioner determines the adoptive parent is no longer providing financial
665.20 support to the child up to age 21;

665.21 (4) the death of the child; or

665.22 (5) the adoptive parent requests in writing the termination of the adoption assistance
665.23 agreement.

665.24 (b) An adoptive parent is considered no longer legally responsible for support of the
665.25 child in any of the following circumstances:

665.26 (1) parental rights to the child are legally terminated or a court accepted the parent's
665.27 consent to adoption under chapter 260C;

665.28 (2) permanent legal and physical custody or guardianship of the child is transferred
665.29 to another individual;

665.30 (3) death of the adoptive parent under subdivision 9;

665.31 (4) the child enlists in the military;

665.32 (5) the child gets married; or

665.33 (6) the child is determined an emancipated minor through legal action.

665.34 Subd. 9. **Death of adoptive parent or adoption dissolution.** The adoption
665.35 assistance agreement ends upon death or termination of parental rights of both adoptive
665.36 parents in the case of a two-parent adoption, or the sole adoptive parent in the case of

666.1 a single-parent adoption. The child's adoption assistance eligibility may be continued
666.2 according to subdivision 10.

666.3 Subd. 10. **Continuing a child's title IV-E adoption assistance in a subsequent**
666.4 **adoption.** (a) The child maintains eligibility for title IV-E adoption assistance in a
666.5 subsequent adoption if the following criteria are met:

666.6 (1) the child is determined to be a child with special needs as outlined in subdivision
666.7 2; and

666.8 (2) the subsequent adoptive parent resides in Minnesota.

666.9 (b) If a child had a title IV-E adoption assistance agreement in effect prior to the
666.10 death of the adoptive parent or dissolution of the adoption, and the subsequent adoptive
666.11 parent resides outside of Minnesota, the commissioner is not responsible for determining
666.12 whether the child meets the definition of special needs, entering into the adoption
666.13 assistance agreement, and making any adoption assistance payments outlined in the new
666.14 agreement unless a state agency in Minnesota has responsibility for placement and care of
666.15 the child at the time of the subsequent adoption. If there is no state agency in Minnesota
666.16 that has responsibility for placement and care of the child at the time of the subsequent
666.17 adoption, the public child welfare agency in the subsequent adoptive parent's residence is
666.18 responsible for determining whether the child meets the definition of special needs and
666.19 entering into the adoption assistance agreement.

666.20 Subd. 11. **Assigning a child's adoption assistance to a court-appointed guardian**
666.21 **or custodian.** (a) State-funded adoption assistance may be continued with the written
666.22 consent of the commissioner to an individual who is a guardian appointed by a court for
666.23 the child upon the death of both the adoptive parents in the case of a two-parent adoption,
666.24 or the sole adoptive parent in the case of a single-parent adoption, unless the child is
666.25 under the custody of a state agency.

666.26 (b) Temporary assignment of adoption assistance may be approved by the
666.27 commissioner for a maximum of six consecutive months from the death of the adoptive
666.28 parent or parents under subdivision 9 and must adhere to the requirements and procedures
666.29 prescribed by the commissioner. If, within six months, the child has not been adopted by a
666.30 person agreed upon by the commissioner, or a court has not appointed a permanent legal
666.31 guardian under section 260C.325, 525.5-313, or similar law of another jurisdiction, the
666.32 adoption assistance must terminate.

666.33 (c) Upon assignment of payments under this subdivision, assistance must be from
666.34 funds other than title IV-E.

667.1 Subd. 12. Extension of adoption assistance agreement. (a) Under certain limited
667.2 circumstances a child may qualify for extension of the adoption assistance agreement
667.3 beyond the date the child attains age 18, up to the date the child attains the age of 21.

667.4 (b) A request for extension of the adoption assistance agreement must be completed
667.5 in writing and submitted, including all supporting documentation, by the adoptive parent
667.6 to the commissioner at least 60 calendar days prior to the date that the current agreement
667.7 will terminate.

667.8 (c) A signed amendment to the current adoption assistance agreement must be
667.9 fully executed between the adoptive parent and the commissioner at least ten business
667.10 days prior to the termination of the current agreement. The request for extension and the
667.11 fully executed amendment must be made according to the requirements and procedures
667.12 prescribed by the commissioner, including documentation of eligibility, on forms
667.13 prescribed by the commissioner.

667.14 (d) If an agency is certifying a child for adoption assistance and the child will attain
667.15 the age of 18 within 60 calendar days of submission, the request for extension must be
667.16 completed in writing and submitted, including all supporting documentation, with the
667.17 adoption assistance application.

667.18 (e) A child who has attained the age of 16 prior to the finalization of the child's
667.19 adoption is eligible for extension of the adoption assistance agreement up to the date the
667.20 child attains age 21 if the child is:

667.21 (1) dependent on the adoptive parent for care and financial support; and

667.22 (2)(i) completing a secondary education program or a program leading to an
667.23 equivalent credential;

667.24 (ii) enrolled in an institution that provides postsecondary or vocational education;

667.25 (iii) participating in a program or activity designed to promote or remove barriers to
667.26 employment;

667.27 (iv) employed for at least 80 hours per month; or

667.28 (v) incapable of doing any of the activities described in items (i) to (iv) due to
667.29 a medical condition where incapability is supported by documentation from an expert
667.30 according to the requirements and procedures prescribed by the commissioner.

667.31 (f) A child who has not attained the age of 16 prior to finalization of the child's
667.32 adoption is eligible for extension of the adoption assistance agreement up to the date the
667.33 child attains the age of 21 if the child is:

667.34 (1) dependent on the adoptive parent for care and financial support; and

667.35 (2)(i) enrolled in a secondary education program or a program leading to the
667.36 equivalent; or

668.1 (ii) possesses a physical or mental disability that impairs the capacity for independent
668.2 living and warrants continuation of financial assistance as determined by the commissioner.

668.3 Subd. 13. **Beginning adoption assistance under Northstar Care for Children.**

668.4 Effective November 27, 2014, a child who meets the eligibility criteria for adoption
668.5 assistance in subdivision 1, may have an adoption assistance agreement negotiated on
668.6 the child's behalf according to section 256N.25, and the effective date of the agreement
668.7 must be January 1, 2015, or the date of the court order finalizing the adoption, whichever
668.8 is later. Except as provided under section 256N.26, subdivision 1, paragraph (c), the
668.9 maximum rate schedule for the agreement must be determined according to section
668.10 256N.26 based on the age of the child on the date that the prospective adoptive parent or
668.11 parents sign the agreement.

668.12 Subd. 14. **Transition to adoption assistance under Northstar Care for Children.**

668.13 The commissioner may offer adoption assistance agreements under this chapter to a
668.14 child with an adoption assistance agreement under chapter 259A executed on the child's
668.15 behalf on or before November 26, 2014, according to the priorities outlined in section
668.16 256N.28, subdivision 7, paragraph (b). To facilitate transition into the Northstar Care for
668.17 Children adoption assistance program, the commissioner has the authority to waive any
668.18 Northstar Care for Children adoption assistance eligibility requirements for a child with
668.19 an adoption assistance agreement under chapter 259A executed on the child's behalf on
668.20 or before November 26, 2014. Agreements negotiated under this subdivision must be in
668.21 accordance with the process in section 256N.28, subdivision 7. The maximum rate used in
668.22 the negotiation process for an agreement under this subdivision must be as outlined in
668.23 section 256N.28, subdivision 7.

668.24 Sec. 11. **[256N.24] ASSESSMENTS.**

668.25 Subdivision 1. **Assessment.** (a) Each child eligible under sections 256N.21,
668.26 256N.22, and 256N.23, must be assessed to determine the benefits the child may receive
668.27 under section 256N.26, in accordance with the assessment tool, process, and requirements
668.28 specified in subdivision 2.

668.29 (b) If an agency applies the emergency foster care rate for initial placement under
668.30 section 256N.26, the agency may wait up to 30 days to complete the initial assessment.

668.31 (c) Unless otherwise specified in paragraph (d), a child must be assessed at the basic
668.32 level, level B, or one of ten supplemental difficulty of care levels, levels C to L.

668.33 (d) An assessment must not be completed for:

669.1 (1) a child eligible for guardianship assistance under section 256N.22 or adoption
669.2 assistance under section 256N.23 who is determined to be an at-risk child. A child under
669.3 this clause must be assigned level A under section 256N.26, subdivision 1; and

669.4 (2) a child transitioning into Northstar Care for Children under section 256N.28,
669.5 subdivision 7, unless the commissioner determines an assessment is appropriate.

669.6 Subd. 2. **Establishment of assessment tool, process, and requirements.** Consistent
669.7 with sections 256N.001 to 256N.28, the commissioner shall establish an assessment tool
669.8 to determine the basic and supplemental difficulty of care, and shall establish the process
669.9 to be followed and other requirements, including appropriate documentation, when
669.10 conducting the initial assessment of a child entering Northstar Care for Children or when
669.11 the special assessment and reassessments may be needed for children continuing in the
669.12 program. The assessment tool must take into consideration the strengths and needs of the
669.13 child and the extra parenting provided by the caregiver to meet the child's needs.

669.14 Subd. 3. **Child care allowance portion of assessment.** (a) The assessment tool
669.15 established under subdivision 2 must include consideration of the caregiver's need for
669.16 child care under this subdivision, with greater consideration for children of younger ages.

669.17 (b) The child's assessment must include consideration of the caregiver's need for
669.18 child care if the following criteria are met:

669.19 (1) the child is under age 13;

669.20 (2) all available adult caregivers are employed or attending educational or vocational
669.21 training programs; and

669.22 (3) the caregiver does not receive child care assistance for the child under chapter
669.23 119B.

669.24 (c) For children younger than seven years of age, the level determined by the
669.25 non-child care portions of the assessment must be adjusted based on the average number
669.26 of hours child care is needed each week due to employment or attending a training or
669.27 educational program as follows:

669.28 (1) fewer than ten hours or if the caregiver is participating in the child care assistance
669.29 program under chapter 119B, no adjustment;

669.30 (2) ten to 19 hours or if needed during school summer vacation or equivalent only,
669.31 increase one level;

669.32 (3) 20 to 29 hours, increase two levels;

669.33 (4) 30 to 39 hours, increase three levels; and

669.34 (5) 40 or more hours, increase four levels.

669.35 (d) For children at least seven years of age but younger than 13, the level determined
669.36 by the non-child care portions of the assessment must be adjusted based on the average

670.1 number of hours child care is needed each week due to employment or attending a training
670.2 or educational program as follows:

670.3 (1) fewer than 20 hours, needed during school summer vacation or equivalent only,
670.4 or if the caregiver is participating in the child care assistance program under chapter
670.5 119B, no adjustment;

670.6 (2) 20 to 39 hours, increase one level; and

670.7 (3) 40 or more hours, increase two levels.

670.8 (e) When the child attains the age of seven, the child care allowance must be reduced
670.9 by reducing the level to that available under paragraph (d). For children in foster care,
670.10 benefits under section 256N.26 must be automatically reduced when the child turns seven.
670.11 For children who receive guardianship assistance or adoption assistance, agreements must
670.12 include similar provisions to ensure that the benefit provided to these children does not
670.13 exceed the benefit provided to children in foster care.

670.14 (f) When the child attains the age of 13, the child care allowance must be eliminated
670.15 by reducing the level to that available prior to any consideration of the caregiver's need
670.16 for child care. For children in foster care, benefits under section 256N.26 must be
670.17 automatically reduced when the child attains the age of 13. For children who receive
670.18 guardianship assistance or adoption assistance, agreements must include similar provisions
670.19 to ensure that the benefit provided to these children does not exceed the benefit provided
670.20 to children in foster care.

670.21 (g) The child care allowance under this subdivision is not available to caregivers
670.22 who receive the child care assistance under chapter 119B. A caregiver receiving a child
670.23 care allowance under this subdivision must notify the commissioner if the caregiver
670.24 subsequently receives the child care assistance program under chapter 119B, and the
670.25 level must be reduced to that available prior to any consideration of the caregiver's need
670.26 for child care.

670.27 (h) In establishing the assessment tool under subdivision 2, the commissioner must
670.28 design the tool so that the levels applicable to the non-child care portions of the assessment
670.29 at a given age accommodate the requirements of this subdivision.

670.30 Subd. 4. **Extraordinary levels.** (a) The assessment tool established under
670.31 subdivision 2 must provide a mechanism through which up to five levels can be added
670.32 to the supplemental difficulty of care for a particular child under section 256N.26,
670.33 subdivision 4. In establishing the assessment tool, the commissioner must design the tool
670.34 so that the levels applicable to the portions of the assessment other than the extraordinary
670.35 levels can accommodate the requirements of this subdivision.

671.1 (b) These extraordinary levels are available when all of the following circumstances
671.2 apply:

671.3 (1) the child has extraordinary needs as determined by the assessment tool provided
671.4 for under subdivision 2, and the child meets other requirements established by the
671.5 commissioner, such as a minimum score on the assessment tool;

671.6 (2) the child's extraordinary needs require extraordinary care and intense supervision
671.7 that is provided by the child's caregiver as part of the parental duties as described in the
671.8 supplemental difficulty of care rate, section 256N.02, subdivision 21. This extraordinary
671.9 care provided by the caregiver is required so that the child can be safely cared for in the
671.10 home and community, and prevents residential placement;

671.11 (3) the child is physically living in a foster family setting, as defined in Minnesota
671.12 Rules, part 2960.3010, subpart 23, or physically living in the home with the adoptive
671.13 parent or relative custodian; and

671.14 (4) the child is receiving the services for which the child is eligible through medical
671.15 assistance programs or other programs that provide necessary services for children with
671.16 disabilities or other medical and behavioral conditions to live with the child's family, but
671.17 the agency with caregiver's input has identified a specific support gap that cannot be met
671.18 through home and community support waivers or other programs that are designed to
671.19 provide support for children with special needs.

671.20 (c) The agency completing an assessment, under subdivision 2, that suggests an
671.21 extraordinary level must document as part of the assessment, the following:

671.22 (1) the assessment tool that determined that the child's needs or disabilities require
671.23 extraordinary care and intense supervision;

671.24 (2) a summary of the extraordinary care and intense supervision that is provided by
671.25 the caregiver as part of the parental duties as described in the supplemental difficulty of
671.26 care rate, section 256N.02, subdivision 21;

671.27 (3) confirmation that the child is currently physically residing in the foster family
671.28 setting or in the home with the adoptive parent or relative custodian;

671.29 (4) the efforts of the agency, caregiver, parents, and others to request support services
671.30 in the home and community that would ease the degree of parental duties provided by the
671.31 caregiver for the care and supervision of the child. This would include documentation of
671.32 the services provided for the child's needs or disabilities, and the services that were denied
671.33 or not available from the local social service agency, community agency, the local school
671.34 district, local public health department, the parent or child's medical insurance provider;

671.35 (5) the specific support gap identified that places the child's safety and well-being at
671.36 risk in the home or community and is necessary to prevent residential placement; and

672.1 (6) the extraordinary care and intense supervision provided by the foster, adoptive,
672.2 or guardianship caregivers to maintain the child safely in the child's home and prevent
672.3 residential placement that cannot be supported by medical assistance or other programs
672.4 that provide services, necessary care for children with disabilities, or other medical or
672.5 behavioral conditions in the home or community.

672.6 (d) An agency completing an assessment under subdivision 2 that suggests
672.7 an extraordinary level is appropriate must forward the assessment and required
672.8 documentation to the commissioner. If the commissioner approves, the extraordinary
672.9 levels must be retroactive to the date the assessment was forwarded.

672.10 Subd. 5. **Timing of initial assessment.** For a child entering Northstar Care for
672.11 Children under section 256N.21, the initial assessment must be completed within 30
672.12 days after the child is placed in foster care.

672.13 Subd. 6. **Completion of initial assessment.** (a) The assessment must be completed
672.14 in consultation with the child's caregiver. Face-to-face contact with the caregiver is not
672.15 required to complete the assessment.

672.16 (b) Initial assessments are completed for foster children, eligible under section
672.17 256N.21.

672.18 (c) The initial assessment must be completed by the financially responsible agency,
672.19 in consultation with the legally responsible agency if different, within 30 days of the
672.20 child's placement in foster care.

672.21 (d) If the foster parent is unable or unwilling to cooperate with the assessment process,
672.22 the child shall be assigned the basic level, level B under section 256N.26, subdivision 3.

672.23 (e) Notice to the foster parent shall be provided as specified in subdivision 12.

672.24 Subd. 7. **Timing of special assessment.** (a) A special assessment is required as part
672.25 of the negotiation of the guardianship assistance agreement under section 256N.22 if:

672.26 (1) the child was not placed in foster care with the prospective relative custodian
672.27 or custodians prior to the negotiation of the guardianship assistance agreement under
672.28 section 256N.25; or

672.29 (2) any requirement for reassessment under subdivision 8 is met.

672.30 (b) A special assessment is required as part of the negotiation of the adoption
672.31 assistance agreement under section 256N.23 if:

672.32 (1) the child was not placed in foster care with the prospective adoptive parent
672.33 or parents prior to the negotiation of the adoption assistance agreement under section
672.34 256N.25; or

672.35 (2) any requirement for reassessment under subdivision 8 is met.

673.1 (c) A special assessment is required when a child transitions from a pre-Northstar
673.2 Care for Children program into Northstar Care for Children if the commissioner
673.3 determines that a special assessment is appropriate instead of assigning the transition child
673.4 to a level under section 256N.28.

673.5 (d) The special assessment must be completed prior to the establishment of a
673.6 guardianship assistance or adoption assistance agreement on behalf of the child.

673.7 Subd. 8. **Completing the special assessment.** (a) The special assessment must
673.8 be completed in consultation with the child's caregiver. Face-to-face contact with the
673.9 caregiver is not required to complete the special assessment.

673.10 (b) If a new special assessment is required prior to the effective date of the
673.11 guardianship assistance agreement, it must be completed by the financially responsible
673.12 agency, in consultation with the legally responsible agency if different. If the prospective
673.13 relative custodian is unable or unwilling to cooperate with the special assessment process,
673.14 the child shall be assigned the basic level, level B under section 256N.26, subdivision 3,
673.15 unless the child is known to be an at-risk child, in which case, the child shall be assigned
673.16 level A under section 256N.26, subdivision 1.

673.17 (c) If a special assessment is required prior to the effective date of the adoption
673.18 assistance agreement, it must be completed by the financially responsible agency, in
673.19 consultation with the legally responsible agency if different. If there is no financially
673.20 responsible agency, the special assessment must be completed by the agency designated by
673.21 the commissioner. If the prospective adoptive parent is unable or unwilling to cooperate
673.22 with the special assessment process, the child must be assigned the basic level, level B
673.23 under section 256N.26, subdivision 3, unless the child is known to be an at-risk child, in
673.24 which case, the child shall be assigned level A under section 256N.26, subdivision 1.

673.25 (d) Notice to the prospective relative custodians or prospective adoptive parents
673.26 must be provided as specified in subdivision 12.

673.27 Subd. 9. **Timing of and requests for reassessments.** Reassessments for an eligible
673.28 child must be completed within 30 days of any of the following events:

673.29 (1) for a child in continuous foster care, when six months have elapsed since
673.30 completion of the last assessment;

673.31 (2) for a child in continuous foster care, change of placement location;

673.32 (3) for a child in foster care, at the request of the financially responsible agency or
673.33 legally responsible agency;

673.34 (4) at the request of the commissioner; or

673.35 (5) at the request of the caregiver under subdivision 9.

674.1 Subd. 10. Caregiver requests for reassessments. (a) A caregiver may initiate
674.2 a reassessment request for an eligible child in writing to the financially responsible
674.3 agency or, if there is no financially responsible agency, the agency designated by the
674.4 commissioner. The written request must include the reason for the request and the
674.5 name, address, and contact information of the caregivers. For an eligible child with a
674.6 guardianship assistance or adoption assistance agreement, the caregiver may request a
674.7 reassessment if at least six months have elapsed since any previously requested review.
674.8 For an eligible foster child, a foster parent may request reassessment in less than six
674.9 months with written documentation that there have been significant changes in the child's
674.10 needs that necessitate an earlier reassessment.

674.11 (b) A caregiver may request a reassessment of an at-risk child for whom a
674.12 guardianship assistance or adoption assistance agreement has been executed if the
674.13 caregiver has satisfied the commissioner with written documentation from a qualified
674.14 expert that the potential disability upon which eligibility for the agreement was based has
674.15 manifested itself, consistent with section 256N.25, subdivision 3, paragraph (b).

674.16 (c) If the reassessment cannot be completed within 30 days of the caregiver's request,
674.17 the agency responsible for reassessment must notify the caregiver of the reason for the
674.18 delay and a reasonable estimate of when the reassessment can be completed.

674.19 Subd. 11. Completion of reassessment. (a) The reassessment must be completed
674.20 in consultation with the child's caregiver. Face-to-face contact with the caregiver is not
674.21 required to complete the reassessment.

674.22 (b) For foster children eligible under section 256N.21, reassessments must be
674.23 completed by the financially responsible agency, in consultation with the legally
674.24 responsible agency if different.

674.25 (c) If reassessment is required after the effective date of the guardianship assistance
674.26 agreement, the reassessment must be completed by the financially responsible agency.

674.27 (d) If a reassessment is required after the effective date of the adoption assistance
674.28 agreement, it must be completed by the financially responsible agency or, if there is no
674.29 financially responsible agency, the agency designated by the commissioner.

674.30 (e) If the child's caregiver is unable or unwilling to cooperate with the reassessment,
674.31 the child must be assessed at level B under section 256N.26, subdivision 3, unless the
674.32 child has an adoption assistance or guardianship assistance agreement in place and is
674.33 known to be an at-risk child, in which case the child must be assessed at level A under
674.34 section 256N.26, subdivision 1.

674.35 Subd. 12. Approval of initial assessments, special assessments, and
674.36 reassessments. (a) Any agency completing initial assessments, special assessments, or

675.1 reassessments must designate one or more supervisors or other staff to examine and approve
675.2 assessments completed by others in the agency under subdivision 2. The person approving
675.3 an assessment must not be the case manager or staff member completing that assessment.

675.4 (b) In cases where a special assessment or reassessment for guardian assistance
675.5 and adoption assistance is required under subdivision 7 or 10, the commissioner shall
675.6 review and approve the assessment as part of the eligibility determination process outlined
675.7 in section 256N.22, subdivision 7, for guardianship assistance, or section 256N.23,
675.8 subdivision 7, for adoption assistance. The assessment determines the maximum for the
675.9 negotiated agreement amount under section 256N.25.

675.10 (c) The new rate is effective the calendar month that the assessment is approved,
675.11 or the effective date of the agreement, whichever is later.

675.12 Subd. 13. **Notice for caregiver.** (a) The agency as defined in subdivision 5 or 10
675.13 that is responsible for completing the initial assessment or reassessment must provide the
675.14 child's caregiver with written notice of the initial assessment or reassessment.

675.15 (b) Initial assessment notices must be sent within 15 days of completion of the initial
675.16 assessment and must minimally include the following:

675.17 (1) a summary of the child's completed individual assessment used to determine the
675.18 initial rating;

675.19 (2) statement of rating and benefit level;

675.20 (3) statement of the circumstances under which the agency must reassess the child;

675.21 (4) procedure to seek reassessment;

675.22 (5) notice that the caregiver has the right to a fair hearing review of the assessment
675.23 and how to request a fair hearing, consistent with section 256.045, subdivision 3; and

675.24 (6) the name, telephone number, and e-mail, if available, of a contact person at the
675.25 agency completing the assessment.

675.26 (c) Reassessment notices must be sent within 15 days after the completion of the
675.27 reassessment and must minimally include the following:

675.28 (1) a summary of the child's individual assessment used to determine the new rating;

675.29 (2) any change in rating and its effective date;

675.30 (3) procedure to seek reassessment;

675.31 (4) notice that if a change in rating results in a reduction of benefits, the caregiver
675.32 has the right to a fair hearing review of the assessment and how to request a fair hearing
675.33 consistent with section 256.045, subdivision 3;

675.34 (5) notice that a caregiver who requests a fair hearing of the reassessed rating within
675.35 ten days may continue at the current rate pending the hearing, but the agency may recover
675.36 any overpayment; and

676.1 (6) name, telephone number, and e-mail, if available, of a contact person at the
676.2 agency completing the reassessment.

676.3 (d) Notice is not required for special assessments since the notice is part of the
676.4 guardianship assistance or adoption assistance negotiated agreement completed according
676.5 to section 256N.25.

676.6 Subd. 14. **Assessment tool determines rate of benefits.** The assessment tool
676.7 established by the commissioner in subdivision 2 determines the monthly benefit level
676.8 for children in foster care. The monthly payment for guardian assistance or adoption
676.9 assistance may be negotiated up to the monthly benefit level under foster care for those
676.10 children eligible for a payment under section 256N.26, subdivision 1.

676.11 Sec. 12. **[256N.25] AGREEMENTS.**

676.12 Subdivision 1. **Agreement; guardianship assistance; adoption assistance.** (a)
676.13 In order to receive guardianship assistance or adoption assistance benefits on behalf of
676.14 an eligible child, a written, binding agreement between the caregiver or caregivers, the
676.15 financially responsible agency, or, if there is no financially responsible agency, the agency
676.16 designated by the commissioner, and the commissioner must be established prior to
676.17 finalization of the adoption or a transfer of permanent legal and physical custody. The
676.18 agreement must be negotiated with the caregiver or caregivers under subdivision 2.

676.19 (b) The agreement must be on a form approved by the commissioner and must
676.20 specify the following:

676.21 (1) duration of the agreement;

676.22 (2) the nature and amount of any payment, services, and assistance to be provided
676.23 under such agreement;

676.24 (3) the child's eligibility for Medicaid services;

676.25 (4) the terms of the payment, including any child care portion as specified in section
676.26 256N.24, subdivision 3;

676.27 (5) eligibility for reimbursement of nonrecurring expenses associated with adopting
676.28 or obtaining permanent legal and physical custody of the child, to the extent that the
676.29 total cost does not exceed \$2,000 per child;

676.30 (6) that the agreement must remain in effect regardless of the state of which the
676.31 adoptive parents or relative custodians are residents at any given time;

676.32 (7) provisions for modification of the terms of the agreement, including renegotiation
676.33 of the agreement; and

676.34 (8) the effective date of the agreement.

677.1 (c) The caregivers, the commissioner, and the financially responsible agency, or, if
677.2 there is no financially responsible agency, the agency designated by the commissioner, must
677.3 sign the agreement. A copy of the signed agreement must be given to each party. Once
677.4 signed by all parties, the commissioner shall maintain the official record of the agreement.

677.5 (d) The effective date of the guardianship assistance agreement must be the date of the
677.6 court order that transfers permanent legal and physical custody to the relative. The effective
677.7 date of the adoption assistance agreement is the date of the finalized adoption decree.

677.8 (e) Termination or disruption of the preadoptive placement or the foster care
677.9 placement prior to assignment of custody makes the agreement with that caregiver void.

677.10 Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible
677.11 for guardianship assistance or adoption assistance, the financially responsible agency, or,
677.12 if there is no financially responsible agency, the agency designated by the commissioner,
677.13 must negotiate with the caregiver to develop an agreement under subdivision 1. If and when
677.14 the caregiver and agency reach concurrence as to the terms of the agreement, both parties
677.15 shall sign the agreement. The agency must submit the agreement, along with the eligibility
677.16 determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to
677.17 the commissioner for final review, approval, and signature according to subdivision 1.

677.18 (b) A monthly payment is provided as part of the adoption assistance or guardianship
677.19 assistance agreement to support the care of children unless the child is determined to be an
677.20 at-risk child, in which case the special at-risk monthly payment under section 256N.26,
677.21 subdivision 7, must be made until the caregiver obtains written documentation from a
677.22 qualified expert that the potential disability upon which eligibility for the agreement
677.23 was based has manifested itself.

677.24 (1) The amount of the payment made on behalf of a child eligible for guardianship
677.25 assistance or adoption assistance is determined through agreement between the prospective
677.26 relative custodian or the adoptive parent and the financially responsible agency, or, if there
677.27 is no financially responsible agency, the agency designated by the commissioner, using
677.28 the assessment tool established by the commissioner in section 256N.24, subdivision 2,
677.29 and the associated benefit and payments outlined in section 256N.26. Except as provided
677.30 under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes
677.31 the monthly benefit level for a child under foster care. The monthly payment under a
677.32 guardianship assistance agreement or adoption assistance agreement may be negotiated up
677.33 to the monthly benefit level under foster care. In no case may the amount of the payment
677.34 under a guardianship assistance agreement or adoption assistance agreement exceed the
677.35 foster care maintenance payment which would have been paid during the month if the

678.1 child with respect to whom the guardianship assistance or adoption assistance payment is
678.2 made had been in a foster family home in the state.

678.3 (2) The rate schedule for the agreement is determined based on the age of the
678.4 child on the date that the prospective adoptive parent or parents or relative custodian or
678.5 custodians sign the agreement.

678.6 (3) The income of the relative custodian or custodians or adoptive parent or parents
678.7 must not be taken into consideration when determining eligibility for guardianship
678.8 assistance or adoption assistance or the amount of the payments under section 256N.26.

678.9 (4) With the concurrence of the relative custodian or adoptive parent, the amount of
678.10 the payment may be adjusted periodically using the assessment tool established by the
678.11 commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under
678.12 subdivision 3 when there is a change in the child's needs or the family's circumstances.

678.13 (5) The guardianship assistance or adoption assistance agreement of a child who is
678.14 identified as at-risk receives the special at-risk monthly payment under section 256N.26,
678.15 subdivision 7, unless and until the potential disability manifests itself, as documented by
678.16 an appropriate professional, and the commissioner authorizes commencement of payment
678.17 by modifying the agreement accordingly. A relative custodian or adoptive parent of an
678.18 at-risk child with a guardianship assistance or adoption assistance agreement may request
678.19 a reassessment of the child under section 256N.24, subdivision 9, and renegotiation of
678.20 the guardianship assistance or adoption assistance agreement under subdivision 3 to
678.21 include a monthly payment, if the caregiver has written documentation from a qualified
678.22 expert that the potential disability upon which eligibility for the agreement was based has
678.23 manifested itself. Documentation of the disability must be limited to evidence deemed
678.24 appropriate by the commissioner.

678.25 (c) For guardianship assistance agreements:

678.26 (1) the initial amount of the monthly guardianship assistance payment must be
678.27 equivalent to the foster care rate in effect at the time that the agreement is signed less any
678.28 offsets under section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to
678.29 by the prospective relative custodian and specified in that agreement, unless the child is
678.30 identified as at-risk or the guardianship assistance agreement is entered into when a child
678.31 is under the age of six;

678.32 (2) an at-risk child must be assigned level A as outlined in section 256N.26 and
678.33 receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless
678.34 and until the potential disability manifests itself, as documented by a qualified expert, and
678.35 the commissioner authorizes commencement of payment by modifying the agreement
678.36 accordingly; and

679.1 (3) the amount of the monthly payment for a guardianship assistance agreement for
679.2 a child, other than an at-risk child, who is under the age of six must be as specified in
679.3 section 256N.26, subdivision 5.

679.4 (d) For adoption assistance agreements:

679.5 (1) for a child in foster care with the prospective adoptive parent immediately prior
679.6 to adoptive placement, the initial amount of the monthly adoption assistance payment
679.7 must be equivalent to the foster care rate in effect at the time that the agreement is signed
679.8 less any offsets in section 256N.26, subdivision 11, or a lesser negotiated amount if agreed
679.9 to by the prospective adoptive parents and specified in that agreement, unless the child is
679.10 identified as at-risk or the adoption assistance agreement is entered into when a child is
679.11 under the age of six;

679.12 (2) an at-risk child must be assigned level A as outlined in section 256N.26 and
679.13 receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless
679.14 and until the potential disability manifests itself, as documented by an appropriate
679.15 professional, and the commissioner authorizes commencement of payment by modifying
679.16 the agreement accordingly;

679.17 (3) the amount of the monthly payment for an adoption assistance agreement for
679.18 a child under the age of six, other than an at-risk child, must be as specified in section
679.19 256N.26, subdivision 5;

679.20 (4) for a child who is in the guardianship assistance program immediately prior
679.21 to adoptive placement, the initial amount of the adoption assistance payment must be
679.22 equivalent to the guardianship assistance payment in effect at the time that the adoption
679.23 assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive
679.24 parent and specified in that agreement; and

679.25 (5) for a child who is not in foster care placement or the guardianship assistance
679.26 program immediately prior to adoptive placement or negotiation of the adoption assistance
679.27 agreement, the initial amount of the adoption assistance agreement must be determined
679.28 using the assessment tool and process in this section and the corresponding payment
679.29 amount outlined in section 256N.26.

679.30 Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive
679.31 parent of a child with a guardianship assistance or adoption assistance agreement may
679.32 request renegotiation of the agreement when there is a change in the needs of the child
679.33 or in the family's circumstances. When a relative custodian or adoptive parent requests
679.34 renegotiation of the agreement, a reassessment of the child must be completed consistent
679.35 with section 256N.24, subdivisions 9 and 10. If the reassessment indicates that the
679.36 child's level has changed, the financially responsible agency or, if there is no financially

680.1 responsible agency, the agency designated by the commissioner or the commissioner's
680.2 designee, and the caregiver must renegotiate the agreement to include a payment with
680.3 the level determined through the reassessment process. The agreement must not be
680.4 renegotiated unless the commissioner, the financially responsible agency, and the caregiver
680.5 mutually agree to the changes. The effective date of any renegotiated agreement must be
680.6 determined by the commissioner.

680.7 (b) A relative custodian or adoptive parent of an at-risk child with a guardianship
680.8 assistance or adoption assistance agreement may request renegotiation of the agreement to
680.9 include a monthly payment higher than the special at-risk monthly payment under section
680.10 256N.26, subdivision 7, if the caregiver has written documentation from a qualified
680.11 expert that the potential disability upon which eligibility for the agreement was based has
680.12 manifested itself. Documentation of the disability must be limited to evidence deemed
680.13 appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment
680.14 of the child must be conducted as outlined in section 256N.24, subdivision 9. The
680.15 reassessment must be used to renegotiate the agreement to include an appropriate monthly
680.16 payment. The agreement must not be renegotiated unless the commissioner, the financially
680.17 responsible agency, and the caregiver mutually agree to the changes. The effective date of
680.18 any renegotiated agreement must be determined by the commissioner.

680.19 (c) Renegotiation of a guardianship assistance or adoption assistance agreement is
680.20 required when one of the circumstances outlined in section 256N.26, subdivision 13,
680.21 occurs.

680.22 **Sec. 13. [256N.26] BENEFITS AND PAYMENTS.**

680.23 Subdivision 1. **Benefits.** (a) There are three benefits under Northstar Care for
680.24 Children: medical assistance, basic payment, and supplemental difficulty of care payment.

680.25 (b) A child is eligible for medical assistance under subdivision 2.

680.26 (c) A child is eligible for the basic payment under subdivision 3, except for a child
680.27 assigned level A under section 256N.24, subdivision 1, because the child is determined to
680.28 be an at-risk child receiving guardianship assistance or adoption assistance.

680.29 (d) A child, including a foster child age 18 to 21, is eligible for an additional
680.30 supplemental difficulty of care payment under subdivision 4, as determined by the
680.31 assessment under section 256N.24.

680.32 (e) An eligible child entering guardianship assistance or adoption assistance under
680.33 the age of six receives a basic payment and supplemental difficulty of care payment as
680.34 specified in subdivision 5.

681.1 (f) A child transitioning in from a pre-Northstar Care for Children program under
 681.2 section 256N.28, subdivision 7, shall receive basic and difficulty of care supplemental
 681.3 payments according to those provisions.

681.4 Subd. 2. **Medical assistance.** Eligibility for medical assistance under this chapter
 681.5 must be determined according to section 256B.055.

681.6 Subd. 3. **Basic monthly rate.** From January 1, 2015, to June 30, 2016, the basic
 681.7 monthly rate must be according to the following schedule:

681.8	<u>Ages 0-5</u>	<u>\$565 per month</u>
681.9	<u>Ages 6-12</u>	<u>\$670 per month</u>
681.10	<u>Ages 13 and older</u>	<u>\$790 per month</u>

681.11 Subd. 4. **Difficulty of care supplemental monthly rate.** From January 1, 2015,
 681.12 to June 30, 2016, the supplemental difficulty of care monthly rate is determined by the
 681.13 following schedule:

681.14	<u>Level A</u>	<u>none (special rate under subdivision 7</u>
681.15		<u>applies)</u>
681.16	<u>Level B</u>	<u>none (basic under subdivision 3 only)</u>
681.17	<u>Level C</u>	<u>\$100 per month</u>
681.18	<u>Level D</u>	<u>\$200 per month</u>
681.19	<u>Level E</u>	<u>\$300 per month</u>
681.20	<u>Level F</u>	<u>\$400 per month</u>
681.21	<u>Level G</u>	<u>\$500 per month</u>
681.22	<u>Level H</u>	<u>\$600 per month</u>
681.23	<u>Level I</u>	<u>\$700 per month</u>
681.24	<u>Level J</u>	<u>\$800 per month</u>
681.25	<u>Level K</u>	<u>\$900 per month</u>
681.26	<u>Level L</u>	<u>\$1,000 per month</u>
681.27	<u>Level M</u>	<u>\$1,100 per month</u>
681.28	<u>Level N</u>	<u>\$1,200 per month</u>
681.29	<u>Level O</u>	<u>\$1,300 per month</u>
681.30	<u>Level P</u>	<u>\$1,400 per month</u>
681.31	<u>Level Q</u>	<u>\$1,500 per month</u>

681.32 A child assigned level A is not eligible for either the basic or supplemental difficulty
 681.33 of care payment, while a child assigned level B is not eligible for the supplemental
 681.34 difficulty of care payment but is eligible for the basic monthly rate under subdivision 3.

681.35 Subd. 5. **Alternate rates for preschool entry and certain transitioned children.**

681.36 A child who entered the guardianship assistance or adoption assistance components
 681.37 of Northstar Care for Children while under the age of six shall receive 50 percent of
 681.38 the amount the child would otherwise be entitled to under subdivisions 3 and 4. The

682.1 commissioner may also use the 50 percent rate for a child who was transitioned into those
682.2 components through declaration of the commissioner under section 256N.28, subdivision 7.

682.3 Subd. 6. **Emergency foster care rate for initial placement.** (a) A child who enters
682.4 foster care due to immediate custody by a police officer or court order, consistent with
682.5 section 260C.175, subdivisions 1 and 2, or equivalent provision under tribal code, shall
682.6 receive the emergency foster care rate for up to 30 days. The emergency foster care rate
682.7 cannot be extended beyond 30 days of the child's placement.

682.8 (b) For this payment rate to be applied, at least one of three conditions must apply:

682.9 (1) the child's initial placement must be in foster care in Minnesota;

682.10 (2) the child's previous placement was more than two years ago; or

682.11 (3) the child's previous placement was for fewer than 30 days and an assessment
682.12 under section 256N.24 was not completed by an agency under section 256N.24.

682.13 (c) The emergency foster care rate consists of the appropriate basic monthly rate
682.14 under subdivision 3 plus a difficulty of care supplemental monthly rate of level D under
682.15 subdivision 4.

682.16 (d) The emergency foster care rate ends under any of three conditions:

682.17 (1) when an assessment under section 256N.24 is completed;

682.18 (2) when the placement ends; or

682.19 (3) after 30 days have elapsed.

682.20 (e) The financially responsible agency, in consultation with the legally responsible
682.21 agency, if different, may replace the emergency foster care rate at any time by completing
682.22 an initial assessment on which a revised difficulty of care supplemental monthly rate
682.23 would be based. Consistent with section 256N.24, subdivision 9, the caregiver may
682.24 request a reassessment in writing for an initial assessment to replace the emergency foster
682.25 care rate. This written request would initiate an initial assessment under section 256N.24,
682.26 subdivision 5. If the revised difficulty of care supplemental level based on the initial
682.27 assessment is higher than level D, then the revised higher rate shall apply retroactively to
682.28 the beginning of the placement. If the revised level is lower, the lower rate shall apply on
682.29 the date the initial assessment was completed.

682.30 (f) If a child remains in foster care placement for more than 30 days, the emergency
682.31 foster care rate ends after the 30th day of placement and an assessment under section
682.32 256N.26 must be completed.

682.33 Subd. 7. **Special at-risk monthly payment for at-risk children in guardianship**
682.34 **assistance and adoption assistance.** A child eligible for guardianship assistance under
682.35 section 256N.22 or adoption assistance under section 256N.23 who is determined to be
682.36 an at-risk child shall receive a special at-risk monthly payment of \$1 per month basic,

683.1 unless and until the potential disability manifests itself and the agreement is renegotiated
683.2 to include reimbursement. Such an at-risk child shall receive neither a supplemental
683.3 difficulty of care monthly rate under subdivision 4 nor home and vehicle modifications
683.4 under subdivision 10, but must be considered for medical assistance under subdivision 2.

683.5 Subd. 8. **Daily rates.** (a) The commissioner shall establish prorated daily rates to
683.6 the nearest cent for the monthly rates under subdivisions 3 to 7. Daily rates must be
683.7 routinely used when a partial month is involved for foster care, guardianship assistance, or
683.8 adoption assistance.

683.9 (b) A full month payment is permitted if a foster child is temporarily absent from
683.10 the foster home if the brief absence does not exceed 14 days and the child's placement
683.11 continues with the same caregiver.

683.12 Subd. 9. **Revision.** By April 1, 2016, for fiscal year 2017, and by each succeeding
683.13 April 1 for the subsequent fiscal year, the commissioner shall review and revise the rates
683.14 under subdivisions 3 to 7 based on the United States Department of Agriculture, Estimates
683.15 of the Cost of Raising a Child, published by the United States Department of Agriculture,
683.16 Agricultural Resources Service, Publication 1411. The revision shall be the average
683.17 percentage by which costs increase for the age ranges represented in the United States
683.18 Department of Agriculture, Estimates of the Cost of Raising a Child, except that in no
683.19 instance must the increase be more than three percent per annum. The monthly rates must
683.20 be revised to the nearest dollar and the daily rates to the nearest cent.

683.21 Subd. 10. **Home and vehicle modifications.** (a) Except for a child assigned level A
683.22 under section 256N.24, subdivision 1, paragraph (d), clause (1), a child who is eligible
683.23 for an adoption assistance agreement may have reimbursement of home and vehicle
683.24 modifications necessary to accommodate the child's special needs upon which eligibility
683.25 for adoption assistance was based and included as part of the negotiation of the agreement
683.26 under section 256N.25, subdivision 2. Reimbursement of home and vehicle modifications
683.27 must not be available for a child who is assessed at level A under subdivision 1, unless
683.28 and until the potential disability manifests itself and the agreement is renegotiated to
683.29 include reimbursement.

683.30 (b) Application for and reimbursement of modifications must be completed
683.31 according to a process specified by the commissioner. The type and cost of each
683.32 modification must be preapproved by the commissioner. The type of home and vehicle
683.33 modifications must be limited to those specified by the commissioner.

683.34 (c) Reimbursement for home modifications as outlined in this subdivision is limited
683.35 to once every five years per child. Reimbursement for vehicle modifications as outlined in
683.36 this subdivision is limited to once every five years per family.

684.1 Subd. 11. **Child income or income attributable to the child.** (a) A monthly
684.2 guardianship assistance or adoption assistance payment must be considered as income
684.3 and resources attributable to the child. Guardianship assistance and adoption assistance
684.4 are exempt from garnishment, except as permissible under the laws of the state where the
684.5 child resides.

684.6 (b) When a child is placed into foster care, any income and resources attributable
684.7 to the child are treated as provided in sections 252.27 and 260C.331, or 260B.331, as
684.8 applicable to the child being placed.

684.9 (c) Consideration of income and resources attributable to the child must be part of
684.10 the negotiation process outlined in section 256N.25, subdivision 2. In some circumstances,
684.11 the receipt of other income on behalf of the child may impact the amount of the monthly
684.12 payment received by the relative custodian or adoptive parent on behalf of the child
684.13 through Northstar Care for Children. Supplemental Security Income (SSI), retirement
684.14 survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and
684.15 black lung benefits are considered income and resources attributable to the child.

684.16 Subd. 12. **Treatment of Supplemental Security Income.** If a child placed in foster
684.17 care receives benefits through Supplemental Security Income (SSI) at the time of foster
684.18 care placement or subsequent to placement in foster care, the financially responsible
684.19 agency may apply to be the payee for the child for the duration of the child's placement in
684.20 foster care. If a child continues to be eligible for SSI after finalization of the adoption or
684.21 transfer of permanent legal and physical custody and is determined to be eligible for a
684.22 payment under Northstar Care for Children, a permanent caregiver may choose to receive
684.23 payment from both programs simultaneously. The permanent caregiver is responsible
684.24 to report the amount of the payment to the Social Security Administration and the SSI
684.25 payment will be reduced as required by the Social Security Administration.

684.26 Subd. 13. **Treatment of retirement survivor's disability insurance, veteran's**
684.27 **benefits, railroad retirement benefits, and black lung benefits.** (a) If a child placed
684.28 in foster care receives retirement survivor's disability insurance, veteran's benefits,
684.29 railroad retirement benefits, or black lung benefits at the time of foster care placement or
684.30 subsequent to placement in foster care, the financially responsible agency may apply to
684.31 be the payee for the child for the duration of the child's placement in foster care. If it is
684.32 anticipated that a child will be eligible to receive retirement survivor's disability insurance,
684.33 veteran's benefits, railroad retirement benefits, or black lung benefits after finalization
684.34 of the adoption or assignment of permanent legal and physical custody, the permanent
684.35 caregiver shall apply to be the payee of those benefits on the child's behalf. The monthly

685.1 amount of the other benefits must be considered an offset to the amount of the payment
685.2 the child is determined eligible for under Northstar Care for Children.

685.3 (b) If a child becomes eligible for retirement survivor's disability insurance, veteran's
685.4 benefits, railroad retirement benefits, or black lung benefits, after the initial amount of the
685.5 payment under Northstar Care for Children is finalized, the permanent caregiver shall
685.6 contact the commissioner to redetermine the payment under Northstar Care for Children.
685.7 The monthly amount of the other benefits must be considered an offset to the amount of
685.8 the payment the child is determined eligible for under Northstar Care for Children.

685.9 (c) If a child ceases to be eligible for retirement survivor's disability insurance,
685.10 veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount
685.11 of the payment under Northstar Care for Children is finalized, the permanent caregiver
685.12 shall contact the commissioner to redetermine the payment under Northstar Care for
685.13 Children. The monthly amount of the payment under Northstar Care for Children must be
685.14 the amount the child was determined to be eligible for prior to consideration of any offset.

685.15 (d) If the monthly payment received on behalf of the child under retirement survivor's
685.16 disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits
685.17 changes after the adoption assistance or guardianship assistance agreement is finalized,
685.18 the permanent caregiver shall notify the commissioner as to the new monthly payment
685.19 amount, regardless of the amount of the change in payment. If the monthly payment
685.20 changes by \$75 or more, even if the change occurs incrementally over the duration of
685.21 the term of the adoption assistance or guardianship assistance agreement, the monthly
685.22 payment under Northstar Care for Children must be adjusted without further consent
685.23 to reflect the amount of the increase or decrease in the offset amount. Any subsequent
685.24 change to the payment must be reported and handled in the same manner. A change of
685.25 monthly payments of less than \$75 is not a permissible reason to renegotiate the adoption
685.26 assistance or guardianship assistance agreement under section 256N.25, subdivision 3.
685.27 The commissioner shall review and revise the limit at which the adoption assistance or
685.28 guardian assistance agreement must be renegotiated in accordance with subdivision 9.

685.29 **Subd. 14. Treatment of child support and Minnesota family investment**
685.30 **program.** (a) If a child placed in foster care receives child support, the child support
685.31 payment may be redirected to the financially responsible agency for the duration of the
685.32 child's placement in foster care. In cases where the child qualifies for Northstar Care
685.33 for Children by meeting the adoption assistance eligibility criteria or the guardianship
685.34 assistance eligibility criteria, any court-ordered child support must not be considered
685.35 income attributable to the child and must have no impact on the monthly payment.

686.1 (b) Consistent with section 256J.24, a child eligible for Northstar Care for Children
686.2 whose caregiver receives a payment on the child's behalf is excluded from a Minnesota
686.3 family investment program assistance unit.

686.4 Subd. 15. **Payments.** (a) Payments to caregivers under Northstar Care for Children
686.5 must be made monthly. Consistent with section 256N.24, subdivision 12, the financially
686.6 responsible agency must send the caregiver the required written notice within 15 days of
686.7 a completed assessment or reassessment.

686.8 (b) Unless paragraph (c) or (d) applies, the financially responsible agency shall pay
686.9 foster parents directly for eligible children in foster care.

686.10 (c) When the legally responsible agency is different than the financially responsible
686.11 agency, the legally responsible agency may make the payments to the caregiver, provided
686.12 payments are made on a timely basis. The financially responsible agency must pay
686.13 the legally responsible agency on a timely basis. Caregivers must have access to the
686.14 financially and legally responsible agencies' records of the transaction, consistent with
686.15 the retention schedule for the payments.

686.16 (d) For eligible children in foster care, the financially responsible agency may pay
686.17 the foster parent's payment for a licensed child-placing agency instead of paying the foster
686.18 parents directly. The licensed child-placing agency must timely pay the foster parents
686.19 and maintain records of the transaction. Caregivers must have access to the financially
686.20 responsible agency's records of the transaction and the child-placing agency's records of
686.21 the transaction, consistent with the retention schedule for the payments.

686.22 Subd. 16. **Effect of benefit on other aid.** Payments received under this section
686.23 must not be considered as income for child care assistance under chapter 119B or any
686.24 other financial benefit. Consistent with section 256J.24, a child receiving a maintenance
686.25 payment under Northstar Care for Children is excluded from any Minnesota family
686.26 investment program assistance unit.

686.27 Subd. 17. **Home and community-based services waiver for persons with**
686.28 **disabilities.** A child in foster care may qualify for home and community-based waived
686.29 services, consistent with section 256B.092 for developmental disabilities, or section
686.30 256B.49 for community alternative care, community alternatives for disabled individuals,
686.31 or traumatic brain injury waivers. A waiver service must not be substituted for the foster
686.32 care program. When the child is simultaneously eligible for waived services and for
686.33 benefits under Northstar Care for Children, the financially responsible agency must
686.34 assess and provide basic and supplemental difficulty of care rates as determined by the
686.35 assessment according to section 256N.24. If it is determined that additional services are

687.1 needed to meet the child's needs in the home that is not or cannot be met by the foster care
687.2 program, the need would be referred to the local waived service program.

687.3 Subd. 18. **Overpayments.** The commissioner has the authority to collect any
687.4 amount of foster care payment, adoption assistance, or guardianship assistance paid
687.5 to a caregiver in excess of the payment due. Payments covered by this subdivision
687.6 include basic maintenance needs payments, supplemental difficulty of care payments, and
687.7 reimbursement of home and vehicle modifications under subdivision 10. Prior to any
687.8 collection, the commissioner or the commissioner's designee shall notify the caregiver in
687.9 writing, including:

687.10 (1) the amount of the overpayment and an explanation of the cause of overpayment;

687.11 (2) clarification of the corrected amount;

687.12 (3) a statement of the legal authority for the decision;

687.13 (4) information about how the caregiver can correct the overpayment;

687.14 (5) if repayment is required, when the payment is due and a person to contact to
687.15 review a repayment plan;

687.16 (6) a statement that the caregiver has a right to a fair hearing review by the
687.17 department; and

687.18 (7) the procedure for seeking a fair hearing review by the department.

687.19 Subd. 19. **Payee.** For adoption assistance and guardianship assistance cases, the
687.20 payment must only be made to the adoptive parent or relative custodian specified on the
687.21 agreement. If there is more than one adoptive parent or relative custodian, both parties will
687.22 be listed as the payee unless otherwise specified in writing according to policies outlined
687.23 by the commissioner. In the event of divorce or separation of the caregivers, a change of
687.24 payee must be made in writing according to policies outlined by the commissioner. If both
687.25 caregivers are in agreement as to the change, it may be made according to a process outlined
687.26 by the commissioner. If there is not agreement as to the change, a court order indicating
687.27 the party who is to receive the payment is needed before a change can be processed. If the
687.28 change of payee is disputed, the commissioner may withhold the payment until agreement
687.29 is reached. A noncustodial caregiver may request notice in writing of review, modification,
687.30 or termination of the adoption assistance or guardianship assistance agreement. In the
687.31 event of the death of a payee, a change of payee consistent with sections 256N.22 and
687.32 256N.23 may be made in writing according to policies outlined by the commissioner.

687.33 Subd. 20. **Notification of change.** (a) A caregiver who has an adoption assistance
687.34 agreement or guardianship assistance agreement in place shall keep the agency
687.35 administering the program informed of changes in status or circumstances which would
687.36 make the child ineligible for the payments or eligible for payments in a different amount.

688.1 (b) For the duration of the agreement, the caregiver agrees to notify the agency
688.2 administering the program in writing within 30 days of any of the following:
688.3 (1) a change in the child's or caregiver's legal name;
688.4 (2) a change in the family's address;
688.5 (3) a change in the child's legal custody status;
688.6 (4) the child's completion of high school, if this occurs after the child attains age 18;
688.7 (5) the end of the caregiver's legal responsibility to support the child based on
688.8 termination of parental rights of the caregiver, transfer of guardianship to another person,
688.9 or transfer of permanent legal and physical custody to another person;
688.10 (6) the end of the caregiver's financial support of the child;
688.11 (7) the death of the child;
688.12 (8) the death of the caregiver;
688.13 (9) the child enlists in the military;
688.14 (10) the child gets married;
688.15 (11) the child becomes an emancipated minor through legal action;
688.16 (12) the caregiver separates or divorces; and
688.17 (13) the child is residing outside the caregiver's home for a period of more than
688.18 30 consecutive days.

688.19 Subd. 21. **Correct and true information.** The caregiver must be investigated for
688.20 fraud if the caregiver reports information the caregiver knows is untrue, the caregiver
688.21 fails to notify the commissioner of changes that may affect eligibility, or the agency
688.22 administering the program receives relevant information that the caregiver did not report.

688.23 Subd. 22. **Termination notice for caregiver.** The agency that issues the
688.24 maintenance payment shall provide the child's caregiver with written notice of termination
688.25 of payment. Termination notices must be sent at least 15 days before the final payment or,
688.26 in the case of an unplanned termination, the notice is sent within three days of the end of
688.27 the payment. The written notice must minimally include the following:

688.28 (1) the date payment will end;
688.29 (2) the reason payments will end and the event that is the basis to terminate payment;
688.30 (3) a statement that the provider has a right to a fair hearing review by the department
688.31 consistent with section 256.045, subdivision 3;
688.32 (4) the procedure to request a fair hearing; and
688.33 (5) the name, telephone number, and e-mail address of a contact person at the agency.

688.34 Sec. 14. **[256N.27] FEDERAL, STATE, AND LOCAL SHARES.**

689.1 Subdivision 1. **Federal share.** For the purposes of determining a child's eligibility
689.2 under title IV-E of the Social Security Act for a child in foster care, the financially
689.3 responsible agency shall use the eligibility requirements outlined in section 472 of the
689.4 Social Security Act. For a child who qualifies for guardianship assistance or adoption
689.5 assistance, the financially responsible agency and the commissioner shall use the
689.6 eligibility requirements outlined in section 473 of the Social Security Act. In each case,
689.7 the agency paying the maintenance payments must be reimbursed for the costs from the
689.8 federal money available for this purpose.

689.9 Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance
689.10 payments as determined under subdivision 4, and an identical share of the pre-Northstar
689.11 Care foster care program under section 260C.4411, subdivision 1, the relative custody
689.12 assistance program under section 257.85, and the pre-Northstar Care for Children adoption
689.13 assistance program under chapter 259A. The commissioner may transfer funds into the
689.14 account if a deficit occurs.

689.15 Subd. 3. **Local share.** (a) The financially responsible agency at the time of
689.16 placement for foster care or finalization of the agreement for guardianship assistance or
689.17 adoption assistance shall pay the local share of the maintenance payments as determined
689.18 under subdivision 4, and an identical share of the pre-Northstar Care for Children foster
689.19 care program under section 260C.4411, subdivision 1, the relative custody assistance
689.20 program under section 257.85, and the pre-Northstar Care for Children adoption assistance
689.21 program under chapter 259A.

689.22 (b) The financially responsible agency shall pay the entire cost of any initial clothing
689.23 allowance, administrative payments to child caring agencies specified in section 317A.907,
689.24 or other support services it authorizes, except as provided under other provisions of law.

689.25 (c) In cases of federally required adoption assistance where there is no financially
689.26 responsible agency as provided in section 256N.24, subdivision 5, the commissioner
689.27 shall pay the local share.

689.28 (d) When an Indian child being placed in Minnesota meets title IV-E eligibility
689.29 defined in section 473(d) of the Social Security Act and is receiving guardianship
689.30 assistance or adoption assistance, the agency or entity assuming responsibility for the
689.31 child is responsible for the nonfederal share of the payment.

689.32 Subd. 4. **Nonfederal share.** (a) The commissioner shall establish a percentage share
689.33 of the maintenance payments, reduced by federal reimbursements under title IV-E of the
689.34 Social Security Act, to be paid by the state and to be paid by the financially responsible
689.35 agency.

690.1 (b) These state and local shares must initially be calculated based on the ratio of the
690.2 average appropriate expenditures made by the state and all financially responsible agencies
690.3 during calendar years 2011, 2012, 2013, and 2014. For purposes of this calculation,
690.4 appropriate expenditures for the financially responsible agencies must include basic and
690.5 difficulty of care payments for foster care reduced by federal reimbursements, but not
690.6 including any initial clothing allowance, administrative payments to child care agencies
690.7 specified in section 317A.907, child care, or other support or ancillary expenditures. For
690.8 purposes of this calculation, appropriate expenditures for the state shall include adoption
690.9 assistance and relative custody assistance, reduced by federal reimbursements.

690.10 (c) For each of the periods January 1, 2015, to June 30, 2016, and fiscal years 2017,
690.11 2018, and 2019, the commissioner shall adjust this initial percentage of state and local
690.12 shares to reflect the relative expenditure trends during calendar years 2011, 2012, 2013, and
690.13 2014, taking into account appropriations for Northstar Care for Children and the turnover
690.14 rates of the components. In making these adjustments, the commissioner's goal shall be to
690.15 make these state and local expenditures other than the appropriations for Northstar Care for
690.16 Children to be the same as they would have been had Northstar Care for Children not been
690.17 implemented, or if that is not possible, proportionally higher or lower, as appropriate. The
690.18 state and local share percentages for fiscal year 2019 must be used for all subsequent years.

690.19 **Subd. 5. Adjustments for proportionate shares among financially responsible**
690.20 **agencies.** (a) The commissioner shall adjust the expenditures under subdivision 4 by each
690.21 financially responsible agency so that its relative share is proportional to its foster care
690.22 expenditures, with the goal of making the local share similar to what the county or tribe
690.23 would have spent had Northstar Care for Children not been enacted.

690.24 (b) For the period January 1, 2015, to June 30, 2016, the relative shares must be as
690.25 determined under subdivision 4 for calendar years 2011, 2012, 2013, and 2014 compared
690.26 with similar costs of all financially responsible agencies.

690.27 (c) For subsequent fiscal years, the commissioner shall update the relative shares
690.28 based on actual utilization of Northstar Care for Children by the financially responsible
690.29 agencies during the previous period, so that those using relatively more than they did
690.30 historically are adjusted upward and those using less are adjusted downward.

690.31 (d) The commissioner must ensure that the adjustments are not unduly influenced by
690.32 onetime events, anomalies, small changes that appear large compared to a narrow historic
690.33 base, or fluctuations that are the results of the transfer of responsibilities to tribal social
690.34 service agencies authorized in section 256.01, subdivision 14b, as part of the American
690.35 Indian Child Welfare Initiative.

691.1 Sec. 15. **[256N.28] ADMINISTRATION AND APPEALS.**

691.2 **Subdivision 1. Responsibilities.** (a) The financially responsible agency shall
691.3 determine the eligibility for Northstar Care for Children for children in foster care under
691.4 section 256N.21, and for those children determined eligible, shall further determine each
691.5 child's eligibility for title IV-E of the Social Security Act, provided the agency has such
691.6 authority under the state title IV-E plan.

691.7 (b) Subject to commissioner review and approval, the financially responsible agency
691.8 shall prepare the eligibility determination for Northstar Care for Children for children in
691.9 guardianship assistance under section 256N.22 and children in adoption assistance under
691.10 section 256N.23. The AFDC relatedness determination, when necessary to determine a
691.11 child's eligibility for title IV-E funding, shall be made only by an authorized agency
691.12 according to policies and procedures prescribed by the commissioner.

691.13 (c) The financially responsible agency is responsible for the administration of
691.14 Northstar Care for Children for children in foster care. The agency designated by the
691.15 commissioner is responsible for assisting the commissioner with the administration of
691.16 Northstar Care for Children for children in guardianship assistance and adoption assistance
691.17 by conducting assessments, reassessments, negotiations, and other activities as specified
691.18 by the commissioner under subdivision 2.

691.19 **Subd. 2. Procedures, requirements, and deadlines.** The commissioner shall
691.20 specify procedures, requirements, and deadlines for the administration of Northstar Care
691.21 for Children in accordance with sections 256N.001 to 256N.28, including for children
691.22 transitioning into Northstar Care for Children under subdivision 7. The commissioner
691.23 shall periodically review all procedures, requirements, and deadlines, including the
691.24 assessment tool and process under section 256N.24, in consultation with counties, tribes,
691.25 and representatives of caregivers, and may alter them as needed.

691.26 **Subd. 3. Administration of title IV-E programs.** The title IV-E foster care,
691.27 guardianship assistance, and adoption assistance programs must operate within the
691.28 statutes, rules, and policies set forth by the federal government in the Social Security Act.

691.29 **Subd. 4. Reporting.** The commissioner shall specify required fiscal and statistical
691.30 reports under section 256.01, subdivision 2, paragraph (q), and other reports as necessary.

691.31 **Subd. 5. Promotion of programs.** Families who adopt a child under the
691.32 commissioner's guardianship must be informed as to the adoption tax credit. The
691.33 commissioner shall actively seek ways to promote the guardianship assistance and
691.34 adoption assistance programs, including informing prospective caregivers of eligible
691.35 children of the availability of guardianship assistance and adoption assistance.

692.1 Subd. 6. Appeals and fair hearings. (a) A caregiver has the right to appeal to the
692.2 commissioner under section 256.045 when eligibility for Northstar Care for Children is
692.3 denied, and when payment or the agreement for an eligible child is modified or terminated.

692.4 (b) A relative custodian or adoptive parent has additional rights to appeal to the
692.5 commissioner pursuant to section 256.045. These rights include when the commissioner
692.6 terminates or modifies the guardianship assistance or adoption assistance agreement or
692.7 when the commissioner denies an application for guardianship assistance or adoption
692.8 assistance. A prospective relative custodian or adoptive parent who disagrees with a
692.9 decision by the commissioner before transfer of permanent legal and physical custody or
692.10 finalization of the adoption may request review of the decision by the commissioner or
692.11 may appeal the decision under section 256.045. A guardianship assistance or adoption
692.12 assistance agreement must be signed and in effect before the court order that transfers
692.13 permanent legal and physical custody or the adoption finalization; however, in some cases,
692.14 there may be extenuating circumstances as to why an agreement was not entered into
692.15 before finalization of permanency for the child. Caregivers who believe that extenuating
692.16 circumstances exist in the case of their child may request a fair hearing. Caregivers have the
692.17 responsibility of proving that extenuating circumstances exist. Caregivers must be required
692.18 to provide written documentation of each eligibility criterion at the fair hearing. Examples
692.19 of extenuating circumstances include: relevant facts regarding the child were known by
692.20 the placing agency and not presented to the caregivers before transfer of permanent legal
692.21 and physical custody or finalization of the adoption, or failure by the commissioner or a
692.22 designee to advise potential caregivers about the availability of guardianship assistance or
692.23 adoption assistance for children in the state foster care system. If an appeals judge finds
692.24 through the fair hearing process that extenuating circumstances existed and that the child
692.25 met all eligibility criteria at the time the transfer of permanent legal and physical custody
692.26 was ordered or the adoption was finalized, the effective date and any associated federal
692.27 financial participation shall be retroactive from the date of the request for a fair hearing.

692.28 Subd. 7. Transitions from pre-Northstar Care for Children programs. (a) A child
692.29 in foster care who remains with the same caregiver shall continue to receive benefits under
692.30 the pre-Northstar Care for Children foster care program under section 256.82. Transitions
692.31 to Northstar Care for Children must occur as provided in section 256N.21, subdivision 6.

692.32 (b) The commissioner may seek to transition into Northstar Care for Children a child
692.33 who is in pre-Northstar Care for Children relative custody assistance under section 257.85
692.34 or pre-Northstar Care for Children adoption assistance under chapter 259A, in accordance
692.35 with these priorities, in order of priority:

692.36 (1) financial and budgetary constraints;

- 693.1 (2) complying with federal regulations;
693.2 (3) converting pre-Northstar Care for Children relative custody assistance under
693.3 section 257.85 to the guardianship assistance component of Northstar Care for Children;
693.4 (4) improving permanency for a child or children;
693.5 (5) maintaining permanency for a child or children;
693.6 (6) accessing additional federal funds; and
693.7 (7) administrative simplification.

693.8 (c) Transitions shall be accomplished according to procedures, deadlines, and
693.9 requirements specified by the commissioner under subdivision 2.

693.10 (d) The commissioner may accomplish a transition of a child from pre-Northstar
693.11 Care for Children relative custody assistance under section 257.85 to the guardianship
693.12 assistance component of Northstar Care for Children by declaration and appropriate notice
693.13 to the caregiver, provided that the benefit for a child under this paragraph is not reduced.

693.14 (e) The commissioner may offer a transition of a child from pre-Northstar Care for
693.15 Children adoption assistance under chapter 259A to the adoption assistance component
693.16 of Northstar Care for Children by contacting the caregiver with an offer. The transition
693.17 must be accomplished only when the caregiver agrees to the offer. The caregiver shall
693.18 have a maximum of 90 days to review and accept the commissioner's offer. If the
693.19 commissioner's offer is not accepted within 90 days, the pre-Northstar Care for Children
693.20 adoption assistance agreement remains in effect until it terminates or a subsequent offer is
693.21 made by the commissioner.

693.22 (f) For a child transitioning into Northstar Care for Children, the commissioner shall
693.23 assign an equivalent assessment level based on the most recently completed supplemental
693.24 difficulty of care level assessment, unless the commissioner determines that arranging
693.25 for a new assessment under section 256N.24 would be more appropriate based on the
693.26 priorities specified in paragraph (b).

693.27 (g) For a child transitioning into Northstar Care for Children, regardless of the age
693.28 of the child, the commissioner shall use the rates under section 256N.26, subdivision 5,
693.29 unless the rates under section 256N.26, subdivisions 3 and 4, are more appropriate based
693.30 on the priorities specified in paragraph (b), as determined by the commissioner.

693.31 Subd. 8. **Purchase of child-specific adoption services.** The commissioner may
693.32 reimburse the placing agency for appropriate adoption services for children eligible
693.33 under section 259A.75.

693.34 Sec. 16. Minnesota Statutes 2012, section 257.85, subdivision 2, is amended to read:

694.1 Subd. 2. **Scope.** The provisions of this section apply to those situations in which
694.2 the legal and physical custody of a child is established with a relative or important friend
694.3 with whom the child has resided or had significant contact according to section 260C.515,
694.4 subdivision 4, by a district court order issued on or after July 1, 1997, but on or before
694.5 November 26, 2014, or a tribal court order issued on or after July 1, 2005, but on or
694.6 before November 26, 2014, when the child has been removed from the care of the parent
694.7 by previous district or tribal court order.

694.8 Sec. 17. Minnesota Statutes 2012, section 257.85, subdivision 5, is amended to read:

694.9 Subd. 5. **Relative custody assistance agreement.** (a) A relative custody assistance
694.10 agreement will not be effective, unless it is signed by the local agency and the relative
694.11 custodian no later than 30 days after the date of the order establishing permanent legal and
694.12 physical custody, and on or before November 26, 2014, except that a local agency may
694.13 enter into a relative custody assistance agreement with a relative custodian more than 30
694.14 days after the date of the order if it certifies that the delay in entering the agreement was
694.15 through no fault of the relative custodian and the agreement is signed and in effect on or
694.16 before November 26, 2014. There must be a separate agreement for each child for whom
694.17 the relative custodian is receiving relative custody assistance.

694.18 (b) Regardless of when the relative custody assistance agreement is signed by the
694.19 local agency and relative custodian, the effective date of the agreement shall be the date of
694.20 the order establishing permanent legal and physical custody.

694.21 (c) If MFIP is not the applicable program for a child at the time that a relative
694.22 custody assistance agreement is entered on behalf of the child, when MFIP becomes
694.23 the applicable program, if the relative custodian had been receiving custody assistance
694.24 payments calculated based upon a different program, the amount of relative custody
694.25 assistance payment under subdivision 7 shall be recalculated under the Minnesota family
694.26 investment program.

694.27 (d) The relative custody assistance agreement shall be in a form specified by the
694.28 commissioner and shall include provisions relating to the following:

694.29 (1) the responsibilities of all parties to the agreement;

694.30 (2) the payment terms, including the financial circumstances of the relative
694.31 custodian, the needs of the child, the amount and calculation of the relative custody
694.32 assistance payments, and that the amount of the payments shall be reevaluated annually;

694.33 (3) the effective date of the agreement, which shall also be the anniversary date for
694.34 the purpose of submitting the annual affidavit under subdivision 8;

695.1 (4) that failure to submit the affidavit as required by subdivision 8 will be grounds
695.2 for terminating the agreement;

695.3 (5) the agreement's expected duration, which shall not extend beyond the child's
695.4 eighteenth birthday;

695.5 (6) any specific known circumstances that could cause the agreement or payments
695.6 to be modified, reduced, or terminated and the relative custodian's appeal rights under
695.7 subdivision 9;

695.8 (7) that the relative custodian must notify the local agency within 30 days of any of
695.9 the following:

695.10 (i) a change in the child's status;

695.11 (ii) a change in the relationship between the relative custodian and the child;

695.12 (iii) a change in composition or level of income of the relative custodian's family;

695.13 (iv) a change in eligibility or receipt of benefits under MFIP, or other assistance
695.14 program; and

695.15 (v) any other change that could affect eligibility for or amount of relative custody
695.16 assistance;

695.17 (8) that failure to provide notice of a change as required by clause (7) will be
695.18 grounds for terminating the agreement;

695.19 (9) that the amount of relative custody assistance is subject to the availability of state
695.20 funds to reimburse the local agency making the payments;

695.21 (10) that the relative custodian may choose to temporarily stop receiving payments
695.22 under the agreement at any time by providing 30 days' notice to the local agency and may
695.23 choose to begin receiving payments again by providing the same notice but any payments
695.24 the relative custodian chooses not to receive are forfeit; and

695.25 (11) that the local agency will continue to be responsible for making relative custody
695.26 assistance payments under the agreement regardless of the relative custodian's place of
695.27 residence.

695.28 Sec. 18. Minnesota Statutes 2012, section 257.85, subdivision 6, is amended to read:

695.29 Subd. 6. **Eligibility criteria.** (a) A local agency shall enter into a relative custody
695.30 assistance agreement under subdivision 5 if it certifies that the following criteria are met:

695.31 (1) the juvenile court has determined or is expected to determine that the child,
695.32 under the former or current custody of the local agency, cannot return to the home of
695.33 the child's parents;

696.1 (2) the court, upon determining that it is in the child's best interests, has issued
696.2 or is expected to issue an order transferring permanent legal and physical custody of
696.3 the child; and

696.4 (3) the child either:

696.5 (i) is a member of a sibling group to be placed together; or

696.6 (ii) has a physical, mental, emotional, or behavioral disability that will require
696.7 financial support.

696.8 When the local agency bases its certification that the criteria in clause (1) or (2) are
696.9 met upon the expectation that the juvenile court will take a certain action, the relative
696.10 custody assistance agreement does not become effective until and unless the court acts as
696.11 expected.

696.12 (b) After November 26, 2014, new relative custody assistance agreements must not
696.13 be executed. Agreements that were signed by all parties on or before November 26, 2014,
696.14 and were not in effect because the proposed transfer of permanent legal and physical
696.15 custody of the child did not occur on or before November 26, 2014, must be renegotiated
696.16 under the terms of Northstar Care for Children in chapter 256N.

696.17 Sec. 19. **[259A.12] NO NEW EXECUTION OF ADOPTION ASSISTANCE**
696.18 **AGREEMENTS.**

696.19 After November 26, 2014, new adoption assistance agreements must not be executed
696.20 under this section. Agreements that were signed on or before November 26, 2014, and
696.21 were not in effect because the adoption finalization of the child did not occur on or before
696.22 November 26, 2014, must be renegotiated according to the terms of Northstar Care for
696.23 Children under chapter 256N. Agreements signed and in effect on or before November 26,
696.24 2014, must continue according to the terms of this section and applicable rules for the
696.25 duration of the agreement, unless the commissioner and the adoptive parents choose to
696.26 renegotiated the agreements under Northstar Care for Children consistent with section
696.27 256N.28, subdivision 7. After November 26, 2014, this section and associated rules must
696.28 be referred to as the pre-Northstar Care for Children adoption assistance program and
696.29 shall apply to children whose adoption assistance agreements were in effect on or before
696.30 November 26, 2014, and whose adoptive parents have not renegotiated their agreements
696.31 according to the terms of Northstar Care for Children.

696.32 Sec. 20. **[260C.4411] PRE-NORTHSTAR CARE FOR CHILDREN FOSTER**
696.33 **CARE PROGRAM.**

697.1 Subdivision 1. **Pre-Northstar Care for Children foster care program.** (a) For a
697.2 child placed in family foster care on or before December 31, 2014, the county of financial
697.3 responsibility under section 256G.02 or tribal agency authorized under section 256.01,
697.4 subdivision 14b, shall pay the local share under section 256N.27, subdivision 3, for foster
697.5 care maintenance including any difficulty of care as defined in Minnesota Rules, part
697.6 9560.0521, subparts 7 and 10. Family foster care includes:

697.7 (1) emergency relative placement under section 245A.035;

697.8 (2) licensed foster family settings, foster residence settings, or treatment foster care
697.9 settings, licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and served by
697.10 a public or private child care agency authorized by Minnesota Rules, parts 9545.0755
697.11 to 9545.0845;

697.12 (3) family foster care homes approved by a tribal agency; and

697.13 (4) unlicensed supervised settings for foster youth ages 18 to 21.

697.14 (b) The county of financial responsibility under section 256G.02 or tribal social
697.15 services agency authorized in section 256.01, subdivision 14b, shall pay the entire cost of
697.16 any initial clothing allowance, administrative payments to child care agencies specified
697.17 in section 317A.907, or any other support services it authorizes, except as otherwise
697.18 provided by law.

697.19 (c) The rates for the pre-Northstar Care for Children foster care program remain
697.20 those in effect on January 1, 2013, continuing the preexisting rate structure for foster
697.21 children who remain with the same caregivers and do not transition into Northstar Care for
697.22 Children under section 256N.21, subdivision 6.

697.23 (d) Difficulty of care payments must be maintained consistent with Minnesota Rules,
697.24 parts 9560.0652 and 9560.0653, using the established reassessment tool in Minnesota
697.25 Rules, part 9560.0654. The preexisting rate structure for the pre-Northstar Care for
697.26 Children foster care program must be maintained, provided that when the number of
697.27 foster children in the program is less than ten percent of the population in 2012, the
697.28 commissioner may apply the same assessment tool to both the pre-Northstar Care for
697.29 Children foster care program and Northstar Care for Children under the authority granted
697.30 in section 256N.24, subdivision 2.

697.31 (e) The county of financial responsibility under section 256G.02 or tribal agency
697.32 authorized under section 256.01, subdivision 14b, shall document the determined
697.33 pre-Northstar Care for Children foster care rate in the case record, including a description
697.34 of each condition on which the difficulty of care assessment is based. The difficulty
697.35 of care rate is reassessed:

697.36 (1) every 12 months;

698.1 (2) at the request of the foster parent; or

698.2 (3) if the child's level of need changes in the current foster home.

698.3 (f) The pre-Northstar Care for Children foster care program must maintain the
698.4 following existing program features:

698.5 (1) monthly payments must be made to the family foster home provider;

698.6 (2) notice and appeal procedures must be consistent with Minnesota Rules, part
698.7 9560.0665; and

698.8 (3) medical assistance eligibility for foster children must continue to be determined
698.9 according to section 256B.055.

698.10 (g) The county of financial responsibility under section 256G.02 or tribal agency
698.11 authorized under section 256.01, subdivision 14b, may continue existing program features,
698.12 including:

698.13 (1) establishing a local fund of county money through which the agency may
698.14 reimburse foster parents for the cost of repairing damage done to the home and contents by
698.15 the foster child and the additional care insurance premium cost of a child who possesses a
698.16 permit or license to drive a car; and

698.17 (2) paying a fee for specific services provided by the foster parent, based on the
698.18 parent's skills, experience, or training. This fee must not be considered foster care
698.19 maintenance.

698.20 (h) The following events end the child's enrollment in the pre-Northstar Care for
698.21 Children foster care program:

698.22 (1) reunification with parent or other relative;

698.23 (2) adoption or transfer of permanent legal and physical custody;

698.24 (3) removal from the current foster home to a different foster home;

698.25 (4) another event that ends the current placement episode; or

698.26 (5) attaining the age of 21.

698.27 **Subd. 2. Consideration of other programs.** (a) When a child in foster care
698.28 is eligible to receive a grant of Retirement Survivors Disability Insurance (RSDI)
698.29 or Supplemental Security Income for the aged, blind, and disabled, or a foster care
698.30 maintenance payment under title IV-E of the Social Security Act, United States Code, title
698.31 42, sections 670 to 676, the child's needs must be met through these programs. Every
698.32 effort must be made to establish a child's eligibility for a title IV-E grant to reimburse the
698.33 county or tribe from the federal funds available for this purpose.

698.34 (b) When a child in foster care qualifies for home and community-based waived
698.35 services under section 256B.49 for community alternative care (CAC), community
698.36 alternatives for disabled individuals (CADI), or traumatic brain injury (TBI) waivers,

699.1 this service does not substitute for the child foster care program. When a foster child is
699.2 receiving waived services benefits, the county of financial responsibility under section
699.3 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, assesses and
699.4 provides foster care maintenance including difficulty of care using the established tool in
699.5 Minnesota Rules, part 9560.0654. If it is determined that additional services are needed to
699.6 meet the child's needs in the home that are not or cannot be met by the foster care program,
699.7 the needs must be referred to the waived service program.

699.8 Sec. 21. **[260C.4412] PAYMENT FOR RESIDENTIAL PLACEMENTS.**

699.9 When a child is placed in a foster care group residential setting under Minnesota
699.10 Rules, parts 2960.0020 to 2960.0710, foster care maintenance payments must be made on
699.11 behalf of the child to cover the cost of providing food, clothing, shelter, daily supervision,
699.12 school supplies, child's personal incidentals and supports, reasonable travel for visitation,
699.13 or other transportation needs associated with the items listed. Daily supervision in the
699.14 group residential setting includes routine day-to-day direction and arrangements to
699.15 ensure the well-being and safety of the child. It may also include reasonable costs of
699.16 administration and operation of the facility.

699.17 **EFFECTIVE DATE.** This section is effective January 1, 2015.

699.18 Sec. 22. **[260C.4413] INITIAL CLOTHING ALLOWANCE.**

699.19 (a) An initial clothing allowance must be available to a child eligible for:

699.20 (1) the pre-Northstar Care for Children foster care program under section 260C.4411,
699.21 subdivision 1; and

699.22 (2) the Northstar Care for Children benefits under section 256N.21.

699.23 (b) An initial clothing allowance must also be available for a foster child in a group
699.24 residential setting based on the child's individual needs during the first 60 days of the
699.25 child's initial placement. The agency must consider the parent's ability to provide for a
699.26 child's clothing needs and the residential facility contracts.

699.27 (c) The county of financial responsibility under section 256G.02 or tribal agency
699.28 authorized under section 256.01, subdivision 14b, shall approve an initial clothing
699.29 allowance consistent with the child's needs. The amount of the initial clothing allowance
699.30 must not exceed the monthly basic rate for the child's age group under section 256N.26,
699.31 subdivision 3.

699.32 **EFFECTIVE DATE.** This section is effective January 1, 2015.

700.1 Sec. 23. Minnesota Statutes 2012, section 260C.446, is amended to read:

700.2 **260C.446 DISTRIBUTION OF FUNDS RECOVERED FOR ASSISTANCE**
700.3 **FURNISHED.**

700.4 When any amount shall be recovered from any source for assistance furnished
700.5 under the provisions of sections 260C.001 to 260C.421 and ~~260C.441~~, there shall be paid
700.6 into the treasury of the state or county in the proportion in which they have respectively
700.7 contributed toward the total assistance paid.

700.8 **EFFECTIVE DATE.** This section is effective January 1, 2015.

700.9 Sec. 24. **REPEALER.**

700.10 (a) Minnesota Statutes 2012, sections 256.82, subdivision 4; and 260C.441, are
700.11 repealed effective January 1, 2015.

700.12 (b) Minnesota Rules, parts 9560.0650, subparts 1, 3, and 6; 9560.0651; and
700.13 9560.0655, are repealed effective January 1, 2015."

700.14 Delete the title and insert:

700.15 "A bill for an act
700.16 relating to state government; establishing the health and human services budget;
700.17 modifying provisions related to health care, continuing care, human services
700.18 licensing, children and family services, program integrity, health-related
700.19 licensing boards, chemical and mental health services, managed care
700.20 organizations, waiver provider standards, home care, and the Department of
700.21 Health; redesigning home and community-based services; establishing payment
700.22 methodologies for home and community-based services; adjusting provider
700.23 rates; setting and modifying fees; modifying autism coverage; modifying
700.24 assistance programs; establishing Northstar care for children; making technical
700.25 changes; requiring studies; requiring reports; appropriating money; amending
700.26 Minnesota Statutes 2012, sections 13.381, subdivisions 2, 10; 13.461, by adding
700.27 subdivisions; 16A.724, subdivisions 2, 3; 16C.10, subdivision 5; 16C.155,
700.28 subdivision 1; 43A.23, by adding a subdivision; 62J.692, subdivisions 1, 3, 4,
700.29 5, 9, by adding a subdivision; 62Q.19, subdivision 1; 103I.005, by adding a
700.30 subdivision; 103I.521; 119B.011, by adding a subdivision; 119B.02, by adding
700.31 a subdivision; 119B.025, subdivision 1; 119B.03, subdivision 4; 119B.05,
700.32 subdivision 1; 119B.13, subdivisions 1, 1a, 3a, 6, 7, by adding subdivisions;
700.33 144.051, by adding subdivisions; 144.0724, subdivisions 4, 6; 144.123,
700.34 subdivision 1; 144.125, subdivision 1; 144.212; 144.213; 144.215, subdivisions
700.35 3, 4; 144.216, subdivision 1; 144.217, subdivision 2; 144.218, subdivision 5;
700.36 144.225, subdivisions 1, 4, 7, 8; 144.226; 144.966, subdivisions 2, 3a; 144.98,
700.37 subdivisions 3, 5, by adding subdivisions; 144.99, subdivision 4; 144A.071,
700.38 subdivision 4b; 144A.351; 144A.43; 144A.44; 144A.45; 144D.01, subdivision 4;
700.39 145.906; 145.986; 145A.17, subdivision 1; 145C.01, subdivision 7; 148B.17,
700.40 subdivision 2; 148E.065, subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5,
700.41 16, 23, 27, 34, 35, 37, by adding subdivisions; 149A.03; 149A.65, by adding
700.42 subdivisions; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4;
700.43 149A.72, subdivisions 3, 9, by adding a subdivision; 149A.73, subdivisions 1,
700.44 2, 4; 149A.74; 149A.91, subdivision 9; 149A.93, subdivisions 3, 6; 149A.94;
700.45 149A.96, subdivision 9; 151.19, subdivisions 1, 3; 151.37, subdivision 4; 151.47,
700.46 subdivision 1, by adding a subdivision; 151.49; 174.30, subdivision 1; 214.12, by

701.1 adding a subdivision; 214.40, subdivision 1; 243.166, subdivisions 4b, 7; 245.03,
 701.2 subdivision 1; 245.462, subdivision 20; 245.4661, subdivisions 5, 6; 245.4682,
 701.3 subdivision 2; 245.4871, subdivision 26; 245.4875, subdivision 8; 245.4881,
 701.4 subdivision 1; 245.91, by adding a subdivision; 245.94, subdivisions 2, 2a;
 701.5 245A.02, subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 8, 9; 245A.04,
 701.6 subdivision 13; 245A.042, subdivision 3; 245A.07, subdivisions 2a, 3; 245A.08,
 701.7 subdivision 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435;
 701.8 245A.144; 245A.1444; 245A.16, subdivision 1; 245A.40, subdivision 5;
 701.9 245A.50; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245D.02;
 701.10 245D.03; 245D.04; 245D.05; 245D.06; 245D.07; 245D.09; 245D.10; 246.18,
 701.11 subdivision 8, by adding a subdivision; 246.54; 252.27, subdivision 2a;
 701.12 252.291, by adding a subdivision; 252.41, subdivision 3; 252.42; 252.43;
 701.13 252.44; 252.45; 252.46, subdivision 1a; 253B.10, subdivision 1; 254B.04,
 701.14 subdivision 1; 254B.13; 256.01, subdivisions 2, 24, 34, by adding subdivisions;
 701.15 256.0112, by adding a subdivision; 256.015, subdivision 1; 256.82, subdivisions
 701.16 2, 3; 256.9657, subdivisions 3, 3a, 4; 256.969, subdivision 29; 256.975,
 701.17 subdivision 7, by adding subdivisions; 256.9754, subdivision 5, by adding
 701.18 subdivisions; 256.98, subdivision 8; 256B.02, subdivision 17, as added, by
 701.19 adding subdivisions; 256B.021, by adding subdivisions; 256B.04, subdivisions
 701.20 18, 21, by adding a subdivision; 256B.055, subdivisions 3a, 6, 10, 14, 15, by
 701.21 adding a subdivision; 256B.056, subdivisions 1, 1c, 3, 4, as amended, 5c, 10, by
 701.22 adding a subdivision; 256B.057, subdivisions 1, 8, 10, by adding a subdivision;
 701.23 256B.06, subdivision 4; 256B.0623, subdivision 2; 256B.0625, subdivisions 9,
 701.24 13, 13e, 19c, 31, 39, 48, 56, 58, by adding subdivisions; 256B.0631, subdivision
 701.25 1; 256B.064, subdivisions 1a, 1b, 2; 256B.0659, subdivision 21; 256B.0755,
 701.26 subdivision 3; 256B.0756; 256B.0911, subdivisions 1, 1a, 3a, 4d, 6, 7, by
 701.27 adding a subdivision; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a,
 701.28 5, by adding a subdivision; 256B.0916, by adding a subdivision; 256B.0917,
 701.29 subdivisions 6, 13, by adding subdivisions; 256B.092, subdivisions 1a, 7,
 701.30 11, 12, by adding subdivisions; 256B.0943, subdivisions 1, 2, 7, by adding a
 701.31 subdivision; 256B.0946; 256B.095; 256B.0951, subdivisions 1, 4; 256B.0952,
 701.32 subdivisions 1, 5; 256B.0955; 256B.097, subdivisions 1, 3; 256B.196,
 701.33 subdivision 2; 256B.431, subdivision 44; 256B.434, subdivision 4, by adding
 701.34 subdivisions; 256B.437, subdivision 6; 256B.439, subdivisions 1, 2, 3, 4, by
 701.35 adding subdivisions; 256B.441, subdivisions 13, 44, 53, by adding subdivisions;
 701.36 256B.49, subdivisions 11a, 12, 13, 14, 15, by adding subdivisions; 256B.4912,
 701.37 subdivisions 1, 2, 3, 7, by adding subdivisions; 256B.4913, subdivisions 5, 6, by
 701.38 adding a subdivision; 256B.492; 256B.493, subdivision 2; 256B.501, by adding
 701.39 a subdivision; 256B.5011, subdivision 2; 256B.5012, by adding subdivisions;
 701.40 256B.69, subdivisions 5c, 5i, 8, 9c, 31, by adding subdivisions; 256B.694;
 701.41 256B.76, subdivisions 1, 2, 4, by adding a subdivision; 256B.761; 256B.764;
 701.42 256B.766; 256B.767; 256D.44, subdivision 5; 256I.05, by adding a subdivision;
 701.43 256J.08, subdivision 24; 256J.21, subdivisions 2, 3; 256J.24, subdivisions 5, 7;
 701.44 256J.35; 256J.621; 256J.626, subdivision 7; 256K.45; 256L.01, subdivisions
 701.45 3a, 5, by adding subdivisions; 256L.02, subdivision 2, by adding subdivisions;
 701.46 256L.03, subdivisions 1, 1a, 3, 5, 6, by adding a subdivision; 256L.04,
 701.47 subdivisions 1, 7, 8, 10, 12, by adding subdivisions; 256L.05, subdivisions
 701.48 1, 2, 3, 3c; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3; 256L.09,
 701.49 subdivision 2; 256L.11, subdivisions 1, 3; 256L.12, subdivision 1; 256L.15,
 701.50 subdivisions 1, 2; 256M.40, subdivision 1; 257.0755, subdivision 1; 257.75,
 701.51 subdivision 7; 257.85, subdivisions 2, 5, 6; 259A.20, subdivision 4; 260B.007,
 701.52 subdivisions 6, 16; 260C.007, subdivisions 6, 31; 260C.446; 260C.635,
 701.53 subdivision 1; 299C.093; 402A.10; 402A.18; 471.59, subdivision 1; 517.001;
 701.54 518A.60; 626.556, subdivisions 2, 3, 10d; 626.557, subdivisions 4, 9, 9a, 9e;
 701.55 626.5572, subdivision 13; Laws 1998, chapter 407, article 6, section 116; Laws
 701.56 2011, First Special Session chapter 9, article 1, section 3; article 2, section 27;
 701.57 article 10, section 3, subdivision 3, as amended; Laws 2012, chapter 247, article
 701.58 6, section 4; Laws 2013, chapter 1, section 6; proposing coding for new law in

702.1 Minnesota Statutes, chapters 62A; 144; 144A; 145; 149A; 151; 214; 245; 245A;
702.2 245D; 254B; 256; 256B; 256J; 256L; 259A; 260C; 402A; proposing coding
702.3 for new law as Minnesota Statutes, chapters 245E; 256N; repealing Minnesota
702.4 Statutes 2012, sections 62J.693; 103I.005, subdivision 20; 144.123, subdivision
702.5 2; 144A.46; 144A.461; 149A.025; 149A.20, subdivision 8; 149A.30, subdivision
702.6 2; 149A.40, subdivision 8; 149A.45, subdivision 6; 149A.50, subdivision 6;
702.7 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53, subdivision 9;
702.8 151.19, subdivision 2; 151.25; 151.45; 151.47, subdivision 2; 151.48; 245A.655;
702.9 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1, 2,
702.10 3, 5, 6, 7; 245B.055; 245B.06; 245B.07; 245B.08; 245D.08; 252.40; 252.46,
702.11 subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, 21; 256.82,
702.12 subdivision 4; 256B.055, subdivisions 3, 5, 10b; 256B.056, subdivision 5b;
702.13 256B.057, subdivisions 1c, 2; 256B.0911, subdivisions 4a, 4b, 4c; 256B.0917,
702.14 subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.096, subdivisions 1, 2, 3,
702.15 4; 256B.14, subdivision 3a; 256B.49, subdivision 16a; 256B.4913, subdivisions
702.16 1, 2, 3, 4; 256B.501, subdivision 8; 256B.5012, subdivision 13; 256J.24;
702.17 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, 10a; 256L.05,
702.18 subdivision 3b; 256L.07, subdivisions 1, 5, 8, 9; 256L.11, subdivisions 5, 6;
702.19 256L.17, subdivisions 1, 2, 3, 4, 5; 260C.441; 485.14; 609.093; Laws 2011, First
702.20 Special Session chapter 9, article 7, section 54, as amended; Minnesota Rules,
702.21 parts 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012; 4668.0016;
702.22 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040; 4668.0050;
702.23 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
702.24 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160;
702.25 4668.0170; 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220;
702.26 4668.0230; 4668.0240; 4668.0800; 4668.0805; 4668.0810; 4668.0815;
702.27 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840; 4668.0845;
702.28 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001; 4669.0010;
702.29 4669.0020; 4669.0030; 4669.0040; 4669.0050; 9525.1860, subparts 3, items B,
702.30 C, 4, item D; 9560.0650, subparts 1, 3, 6; 9560.0651; 9560.0655."

703.1 We request the adoption of this report and repassage of the bill.

703.2 House Conferees:

703.3
703.4 Thomas Huntley Tina Liebling

703.5
703.6 Diane Loeffler Rena Moran

703.7
703.8 Jim Abeler

703.9 Senate Conferees:

703.10
703.11 Tony Lourey Kathy Sheran

703.12
703.13 Jeff Hayden Melisa Franzen

703.14
703.15 Melissa H. Wiklund