State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 3215

03/19/2014 Authored by Huntley and Norton
The bill was read for the first time and referred to the Committee on Civil Law
03/26/2014 Adoption of Report: Re-referred to the Committee on Judiciary Finance and Policy
03/27/2014 Adoption of Report: Amended and re-referred to the Committee on Health and Human Services Finance

A bill for an act

relating to the operation of state government; making changes to provisions relating to the Department of Health, Northstar Care for Children program, continuing care, community first services and supports, health care, and chemical dependency; modifying the hospital payment system; modifying provisions governing background studies and home and community-based services standards; setting fees; providing rate increases; amending Minnesota Statutes 2012, sections 13.46, subdivision 4; 245C.03, by adding a subdivision; 245C.04, by adding a subdivision; 245C.05, subdivision 5; 245C.10, by adding a subdivision; 245C.33, subdivisions 1, 4; 252.451, subdivision 2; 254B.12; 256.01, by adding a subdivision; 256.9685, subdivisions 1, 1a; 256.9686, subdivision 2; 256.969, subdivisions 1, 2, 2b, 2c, 3a, 3b, 6a, 9, 10, 14, 17, 30, by adding subdivisions; 256B.0625, subdivision 30; 256B.199; 256B.5012, by adding a subdivision; 256I.05, subdivision 2; 257.85, subdivision 11; 260C.212, subdivision 1; 260C.515, subdivision 4; 260C.611; Minnesota Statutes 2013 Supplement, sections 245.8251; 245A.042, subdivision 3; 245C.08, subdivision 1; 245D.02, subdivisions 3, 4b, 8b, 11, 15b, 29, 34, 34a, by adding a subdivision; 245D.03, subdivisions 1, 2, 3, by adding a subdivision; 245D.04, subdivision 3; 245D.05, subdivisions 1, 1a, 1b, 2, 4, 5; 245D.051; 245D.06, subdivisions 2, 4, 6, 7, 8; 245D.071, subdivisions 3, 4, 5; 245D.081, subdivision 2; 245D.09, subdivisions 3, 4a; 245D.091, subdivisions 2, 3, 4; 245D.10, subdivision 3; 245D.11, subdivision 2; 256B.04, subdivision 21; 256B.055, subdivision 1; 256B.439, subdivisions 1, 7; 256B.4912, subdivision 1; 256B.85, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 23, 24, by adding subdivisions; 256N.02, by adding a subdivision; 256N.21, subdivision 2, by adding a subdivision; 256N.22, subdivisions 1, 2, 4, 6; 256N.23, subdivisions 1, 4; 256N.24, subdivisions 9, 10; 256N.25, subdivisions 2, 3; 256N.26, subdivision 1; 256N.27, subdivision 4; Laws 2013, chapter 108, article 7, section 49; article 14, section 2, subdivision 6; proposing coding for new law in Minnesota Statutes, chapter 144A; repealing Minnesota Statutes 2012, sections 245.825, subdivisions 1, 1b; 256.969, subdivisions 8b, 9a, 9b, 11, 13, 20, 21, 22, 25, 26, 27, 28; 256.9695, subdivisions 3, 4; Minnesota Statutes 2013 Supplement, sections 245D.02, subdivisions 2b, 2c, 3b, 5a, 8a, 15a, 15b, 23b, 28, 29, 34a; 245D.06, subdivisions 5, 6, 7, 8; 245D.061, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9; 256N.26, subdivision 7; Minnesota Rules, parts 9525.2700; 9525.2810.

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

ARTICLE 1

HEALTH DEPARTMENT

Section 1. **[144A.484] INTEGRATED LICENSURE; HOME AND COMMUNITY-BASED SERVICES DESIGNATION.**

Subdivision 1. **Integrated licensing established.** (a) From January 1, 2014, to June 30, 2015, the commissioner of health shall enforce the home and community-based services standards under chapter 245D for those providers who also have a home care license pursuant to chapter 144A as required under Laws 2013, chapter 108, article 11, section 31, and article 8, section 60.

(b) Beginning July 1, 2015, a home care provider applicant or license holder may apply to the commissioner of health for a home and community-based services designation for the provision of basic home and community-based services identified under section 245D.03, subdivision 1, paragraph (b). The designation allows the license holder to provide basic home and community-based services that would otherwise require licensure under chapter 245D, under the license holder's home care license governed by sections 144A.43 to 144A.481.

Subd. 2. **Application for home and community-based services designation.** An application for a home and community-based services designation must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction for completing the application and provide information about the requirements of other state agencies that affect the applicant. Application for the home and community-based services designation is subject to the requirements under section 144A.473.

Subd. 3. **Home and community-based services designation fees.** A home care provider applicant or licensee applying for the home and community-based services designation or renewal of a home and community-based services designation must submit a fee in the amount specified in subdivision 8.

Subd. 4. **Applicability of home and community-based services requirements.** A home care provider with a home and community-based services designation must comply with the requirements for home care services governed by this chapter. For the provision of basic home and community-based services, the home care provider must also comply with the following home and community-based services licensing requirements:

(1) person-centered planning requirements in section 245D.07;

(2) protection standards in section 245D.06;

(3) emergency use of manual restraints in section 245D.061; and

(4) service recipient rights in section 245D.04, subdivision 3, paragraph (a), clauses (5), (7), (8), (12), and (13), and paragraph (b).

A home care provider with the integrated license-HCBS designation may utilize a bill of rights which incorporates the service recipient rights in section 245D.04, subdivision 3, paragraph (a), clauses (5), (7), (8), (12), and (13), and paragraph (b) with the home care bill of rights in section 144A.44.

Subd. 5. **Monitoring and enforcement.** (a) The commissioner shall monitor for compliance with the home and community-based services requirements identified in subdivision 5, in accordance with this section and any agreements by the commissioners of health and human services.

(b) The commissioner shall enforce compliance with applicable home and community-based services licensing requirements as follows:

(1) the commissioner may deny a home and community-based services designation in accordance with section 144A.473 or 144A.475; and

(2) if the commissioner finds that the applicant or license holder has failed to comply with the applicable home and community-based services designation requirements the commissioner may issue:

(i) a correction order in accordance with section 144A.474;

(ii) an order of conditional license in accordance with section 144A.475;

(iii) a sanction in accordance with section 144A.475; or

(iv) any combination of clauses (i) to (iii).

Subd. 6. **Appeals.** A home care provider applicant that has been denied a temporary license will also be denied their application for the home and community-based services designation. The applicant may request reconsideration in accordance with section 144A.473, subdivision 3. A licensed home care provider whose application for a home and community-based services designation has been denied or whose designation has been suspended or revoked may appeal the denial, suspension, revocation, or refusal to renew a home and community-based services designation in accordance with section 144A.475. A license holder may request reconsideration of a correction order in accordance with section 144A.474, subdivision 12.

Subd. 7. **Agreements.** The commissioners of health and human services shall enter into any agreements necessary to implement this section.

Subd. 8. **Fees; home and community-based services designation.** (a) The initial fee for a basic home and community-based services designation is $155. A home care provider who is seeking to renew the provider's home and community-based services designation must pay an annual nonrefundable fee with the annual home care license

fee according to the following schedule and based on revenues from the home and community-based services:

Provider Annual Revenue from HCBS	HCBS Designation
greater than $1,500,000	$320
greater than $1,275,000 and no more than $1,500,000	$300
greater than $1,100,000 and no more than $1,275,000	$280
greater than $950,000 and no more than $1,100,000	$260
greater than $850,000 and no more than $950,000	$240
greater than $750,000 and no more than $850,000	$220
greater than $650,000 and no more than $750,000	$200
greater than $550,000 and no more than $650,000	$180
greater than $450,000 and no more than $550,000	$160
greater than $350,000 and no more than $450,000	$140
greater than $250,000 and no more than $350,000	$120
greater than $100,000 and no more than $250,000	$100
greater than $50,000 and no more than $100,000	$80
greater than $25,000 and no more than $50,000	$60
no more than $25,000	$40

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

EFFECTIVE DATE. Minnesota Statutes, section 144A.484, subdivisions 2 to 8, are effective July 1, 2015.

Sec. 2. Minnesota Statutes 2013 Supplement, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A or that is licensed by the Department of Health under chapter 144A and has a HCBS designation on the home care license must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner.

(2) At the time of initial enrollment or reenrollment, the provider agency must purchase a performance bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a performance bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a performance bond of $100,000. The performance bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(h) The Department of Human Services may require a provider to purchase a performance surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The performance bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The performance bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision to read:

Subd. 38. **Contract to match recipient third-party liability information.** The commissioner may enter into a contract with a national organization to match recipient

third-party liability information and provide coverage and insurance primacy information to the department at no charge to providers and the clearinghouses.

Sec. 2. Minnesota Statutes 2012, section 256.9685, subdivision 1, is amended to read:

Subdivision 1. **Authority.** (a) The commissioner shall establish procedures for determining medical assistance ~~and general assistance medical care~~ payment rates under a prospective payment system for inpatient hospital services in hospitals that qualify as vendors of medical assistance. The commissioner shall establish, by rule, procedures for implementing this section and sections 256.9686, 256.969, and 256.9695. Services must meet the requirements of section 256B.04, subdivision 15, ~~or 256D.03, subdivision 7, paragraph (b),~~ to be eligible for payment.

(b) The commissioner may reduce the types of inpatient hospital admissions that are required to be certified as medically necessary after notice in the State Register and a 30-day comment period.

Sec. 3. Minnesota Statutes 2012, section 256.9685, subdivision 1a, is amended to read:

Subd. 1a. **Administrative reconsideration.** Notwithstanding ~~sections~~ section 256B.04, subdivision 15, ~~and 256D.03, subdivision 7,~~ the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. A physician or hospital may request a reconsideration of the decision that inpatient hospital services are not medically necessary by submitting a written request for review to the commissioner within 30 days after receiving notice of the decision. The reconsideration process shall take place prior to the procedures of subdivision 1b and shall be conducted by physicians that are independent of the case under reconsideration. A majority decision by the physicians is necessary to make a determination that the services were not medically necessary.

Sec. 4. Minnesota Statutes 2012, section 256.9686, subdivision 2, is amended to read:

Subd. 2. **Base year.** "Base year" means a hospital's fiscal year or years that is recognized by the Medicare program or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information by the Medicare program from which cost and statistical data are used to establish medical assistance ~~and general assistance medical care~~ payment rates.

Sec. 5. Minnesota Statutes 2012, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the third quarter of the calendar year prior to the rate year. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis.

(b) ~~For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance, nor under general assistance medical care, except that the inflation adjustments under paragraph (a) for medical assistance, excluding general assistance medical care, shall apply through calendar year 2001. The index for calendar year 2000 shall be reduced 2.5 percentage points to recover overprojections of the index from 1994 to 1996.~~ The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in hospital payment rates under medical assistance ~~and general assistance medical care,~~ based upon the hospital cost index.

Sec. 6. Minnesota Statutes 2012, section 256.969, subdivision 2, is amended to read:

Subd. 2. **Diagnostic categories.** The commissioner shall use to the extent possible existing diagnostic classification systems, including the system ~~used by the Medicare program~~ created by 3M for all patient refined diagnosis-related groups (APR-DRGs) to determine the relative values of inpatient services and case mix indices. The commissioner may combine diagnostic classifications into diagnostic categories and may establish separate categories and numbers of categories based on ~~program eligibility or~~ hospital peer group. Relative values shall be recalculated when the base year is changed. Relative value determinations shall include paid claims for admissions during each hospital's base year. The commissioner may ~~extend the time period forward to obtain sufficiently valid information to establish relative values~~ supplement the APR-DRG data with national averages. Relative value determinations shall not include property cost data, Medicare crossover data, and data on admissions that are paid a per day transfer rate under subdivision 14. The computation of the base year cost per admission must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs recognized in outlier payments beyond that point. The commissioner may recategorize the diagnostic classifications and recalculate relative values and case mix indices to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories after notice in the State Register ~~and a~~

~~30-day comment period. The commissioner shall recategorize the diagnostic classifications and recalculate relative values and case mix indices based on the two-year schedule in effect prior to January 1, 2013, reflected in subdivision 2b. The first recategorization shall occur January 1, 2013, and shall occur every two years after. When rates are not rebased under subdivision 2b, the commissioner may establish relative values and case mix indices based on charge data and may update the base year to the most recent data available~~.

Sec. 7. Minnesota Statutes 2012, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Operating payment rates.** ~~In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009.~~ For the rebased period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent rate setting periods in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals. ~~Effective January 1, 2013, and after, rates shall not be rebased.~~ The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance ~~and shall not include property cost information and costs recognized in outlier payments~~. In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the operating payment rate per admission must be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

Sec. 8. Minnesota Statutes 2012, section 256.969, subdivision 2c, is amended to read:

Subd. 2c. **Property payment rates.** ~~For each hospital's first two consecutive fiscal years beginning on or after July 1, 1988, the commissioner shall limit the annual~~

~~increase in property payment rates for depreciation, rents and leases, and interest expense to the annual growth in the hospital cost index derived from the methodology in effect on the day before July 1, 1989. When computing budgeted and settlement property payment rates, the commissioner shall use the annual increase in the hospital cost index forecasted by Data Resources, Inc., consistent with the quarter of the hospital's fiscal year end. For admissions occurring on or after the rate year beginning January 1, 1991, the commissioner shall obtain property data from an updated base year and establish property payment rates per admission for each hospital.~~ Property payment rates shall be derived from data from the same base year that is used to establish operating payment rates. The property information shall include cost categories not subject to the hospital cost index and shall reflect the cost-finding methods and allowable costs of the Medicare program. ~~The base year property payment rates shall be adjusted for increases in the property cost by increasing the base year property payment rate 85 percent of the percentage change from the base year through the year for which a Medicare cost report has been submitted to the Medicare program and filed with the department by the October 1 before the rate year.~~ The property rates shall only reflect inpatient services covered by medical assistance. ~~The commissioner shall adjust rates for the rate year beginning January 1, 1991, to ensure that all hospitals are subject to the hospital cost index limitation for two complete years.~~

Sec. 9. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 2d. **Budget neutrality factor.** For the rebased period effective September 1, 2014, when rebasing rates under subdivisions 2b and 2c, the commissioner must apply a budget neutrality factor (BNF) to a hospital's conversion factor to ensure that total DRG payments to hospitals do not exceed total DRG payments that would have been made to hospitals if the relative rates and weights had not been recalibrated. For the purposes of this section, BNF equals the percentage change from total aggregate payments calculated under a new payment system to total aggregate payments calculated under the old system.

Sec. 10. Minnesota Statutes 2012, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** ~~(a)~~ Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual

hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. ~~This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991.~~ Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates ~~by December 1 of the year preceding the rate year~~ 30 days prior to implementation. The rate setting data must reflect the admissions data used to establish relative values. ~~Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1.~~ The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

~~(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.~~

~~(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432, and facilities defined under subdivision 16 are excluded from this paragraph.~~

~~(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.~~

~~(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 3.46 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2009, through June 30, 2009, to reflect this reduction.~~

~~(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.~~

~~(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.~~

~~(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.~~

~~(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.~~

Sec. 11. Minnesota Statutes 2012, section 256.969, subdivision 3b, is amended to read:

Subd. 3b. **Nonpayment for hospital-acquired conditions and for certain treatments.** (a) The commissioner must not make medical assistance payments to a hospital for any costs of care that result from a condition listed in paragraph (c), if the condition was hospital acquired.

(b) For purposes of this subdivision, a condition is hospital acquired if it is not identified by the hospital as present on admission. For purposes of this subdivision, medical assistance includes ~~general assistance medical care and~~ MinnesotaCare.

(c) The prohibition in paragraph (a) applies to payment for each hospital-acquired condition listed in this paragraph that is represented by an ~~ICD-9-CM~~ ICD-10-CM diagnosis code ~~and is designated as a complicating condition or a major complicating condition:~~. The list of conditions is defined by the Centers for Medicare and Medicaid Services on an annual basis with the hospital-acquired conditions (HAC) list:

(1) foreign object retained after surgery ~~(ICD-9-CM codes 998.4 or 998.7)~~;

(2) air embolism ~~(ICD-9-CM code 999.1)~~;

(3) blood incompatibility ~~(ICD-9-CM code 999.6)~~;

(4) pressure ulcers stage III or IV ~~(ICD-9-CM codes 707.23 or 707.24)~~;

(5) falls and trauma, including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock ~~(ICD-9-CM codes with these ranges on the complicating condition and major complicating condition list: 800-829; 830-839; 850-854; 925-929; 940-949; and 991-994)~~;

(6) catheter-associated urinary tract infection ~~(ICD-9-CM code 996.64)~~;

(7) vascular catheter-associated infection ~~(ICD-9-CM code 999.31)~~;

(8) manifestations of poor glycemic control ~~(ICD-9-CM codes 249.10; 249.11; 249.20; 249.21; 250.10; 250.11; 250.12; 250.13; 250.20; 250.21; 250.22; 250.23; and 251.0)~~;

(9) surgical site infection ~~(ICD-9-CM codes 996.67 or 998.59)~~ following certain orthopedic procedures ~~(procedure codes 81.01; 81.02; 81.03; 81.04; 81.05; 81.06; 81.07;~~

~~81.08; 81.23; 81.24; 81.31; 81.32; 81.33; 81.34; 81.35; 81.36; 81.37; 81.38; 81.83; and 81.85)~~;

(10) surgical site infection ~~(ICD-9-CM code 998.59)~~ following bariatric surgery ~~(procedure codes 44.38; 44.39; or 44.95)~~ for a principal diagnosis of morbid obesity ~~(ICD-9-CM code 278.01)~~;

(11) surgical site infection, mediastinitis ~~(ICD-9-CM code 519.2)~~ following coronary artery bypass graft ~~(procedure codes 36.10 to 36.19)~~; and

(12) deep vein thrombosis ~~(ICD-9-CM codes 453.40 to 453.42)~~ or pulmonary embolism ~~(ICD-9-CM codes 415.11 or 415.19)~~ following total knee replacement ~~(procedure code 81.54)~~ or hip replacement ~~(procedure codes 00.85 to 00.87 or 81.51 to 81.52)~~.

(d) The prohibition in paragraph (a) applies to any additional payments that result from a hospital-acquired condition listed in paragraph (c), including, but not limited to, additional treatment or procedures, readmission to the facility after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital. In the event of a transfer to another hospital, the hospital where the condition listed under paragraph (c) was acquired is responsible for any costs incurred at the hospital to which the patient is transferred.

(e) A hospital shall not bill a recipient of services for any payment disallowed under this subdivision.

Sec. 12. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one of the following criteria must annually file medical assistance cost reports within six months of the end of the hospital's fiscal year:

(1) a hospital designated as a critical access hospital that receives medical assistance payments; or

(2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade area that receives a disproportionate population adjustment under subdivision 9.

For purposes of this subdivision, local trade area has the meaning given in subdivision 17.

(b) The Department of Human Services must suspend payments to any hospital that fails to file a report required under this subdivision. Payments must remain suspended until the report has been filed with and accepted by the Department of Human Services inpatient rates unit.

Sec. 13. Minnesota Statutes 2012, section 256.969, subdivision 6a, is amended to read:

Subd. 6a. **Special considerations.** In determining the payment rates, the commissioner shall consider whether the circumstances in subdivisions ~~7~~ 8 to 14 exist.

Sec. 14. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 8c. **Hospital residents.** Payments for hospital residents shall be made as follows:

(1) payments for the first 180 days of inpatient care shall be the APR-DRG payment plus any appropriate outliers; and

(2) payment for all medically necessary patient care subsequent to 180 days shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge ratio by the usual and customary charges.

Sec. 15. Minnesota Statutes 2012, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. ~~The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance~~

~~medical care.~~ The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers, critical access hospitals, and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers, critical access hospitals, and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. ~~The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care.~~ The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class~~;~~.

~~(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any~~

~~other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995; and~~

~~(4) effective August 1, 2005, the payments in paragraph (b), clause (3), shall be reduced to zero.~~

~~(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in clause (3).~~

~~(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.~~

~~(e) For purposes of this subdivision, medical assistance does not include general assistance medical care.~~

~~(f) For hospital services occurring on or after July 1, 2005, to June 30, 2007:~~

~~(1) general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be considered Medicaid disproportionate share hospital payments, except as limited below:~~

~~(i) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph (b), clauses (1) and (2), may be used for general assistance medical care expenditures;~~

~~(ii) only those general assistance medical care expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;~~

~~(iii) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and~~

~~(iv) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.~~

~~All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures; and~~

~~(2)~~ (c) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made

beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

~~(g)~~ (d) Upon federal approval of the related state plan amendment, paragraph ~~(f)~~ (c) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

Sec. 16. Minnesota Statutes 2012, section 256.969, subdivision 10, is amended to read:

Subd. 10. **Separate billing by certified registered nurse anesthetists.** Hospitals ~~may~~ must exclude certified registered nurse anesthetist costs from the operating payment rate ~~as allowed by section 256B.0625, subdivision 11. To be eligible, a hospital must notify the commissioner in writing by October 1 of even-numbered years to exclude certified registered nurse anesthetist costs. The hospital must agree that all hospital claims for the cost and charges of certified registered nurse anesthetist services will not be included as part of the rates for inpatient services provided during the rate year. In this case, the operating payment rate shall be adjusted to exclude the cost of certified registered nurse anesthetist services~~.

~~For admissions occurring on or after July 1, 1991, and until the expiration date of section 256.9695, subdivision 3, services of certified registered nurse anesthetists provided on an inpatient basis may be paid as allowed by section 256B.0625, subdivision 11, when the hospital's base year did not include the cost of these services. To be eligible, a hospital must notify the commissioner in writing by July 1, 1991, of the request and must comply with all other requirements of this subdivision.~~

Sec. 17. Minnesota Statutes 2012, section 256.969, subdivision 14, is amended to read:

Subd. 14. **Transfers.** ~~Except as provided in subdivisions 11 and 13,~~ Operating and property payment rates for admissions that result in transfers and transfers shall be established on a per day payment system. The per day payment rate shall be the sum of the adjusted operating and property payment rates determined under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and ~~7~~ 8 to 12, divided by the arithmetic mean length of stay for the diagnostic category. Each admission that results in a transfer and each transfer is considered a separate admission to each hospital, and the total of the admission and transfer payments to each hospital must not exceed the total per admission payment that would otherwise be made to each hospital under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and ~~7 to 13~~ 8 to 12.

Sec. 18. Minnesota Statutes 2012, section 256.969, subdivision 17, is amended to read:

Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are located within a Minnesota local trade area and that have more than 20 admissions in the base year or years shall have rates established using the same procedures and methods that apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means a county contiguous to Minnesota and located in a metropolitan statistical area as determined by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are not required by law to file information in a format necessary to establish rates shall have rates established based on the commissioner's estimates of the information. Relative values of the diagnostic categories shall not be redetermined under this subdivision until required by ~~rule~~ statute. Hospitals affected by this subdivision shall then be included in determining relative values. However, hospitals that have rates established based upon the commissioner's estimates of information shall not be included in determining relative values. This subdivision is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall provide the information necessary to establish rates under this subdivision at least 90 days before the start of the hospital's fiscal year.

Sec. 19. Minnesota Statutes 2012, section 256.969, subdivision 30, is amended to read:

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after ~~October 1, 2009~~ September 1, 2014, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the ~~diagnostic~~ APR-DRG categories: (1) ~~371 cesarean section without complicating diagnosis~~ 5601, 5602, 5603, 5604 vaginal delivery; and (2) ~~372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis~~ 5401, 5402, 5403, 5404 cesarean section, shall be no greater than $3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

Sec. 20. Minnesota Statutes 2012, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(h) By July 1 of each year, the commissioner shall notify federally qualified health centers and rural health clinics enrolled in medical assistance of the commissioner's intent to close out payment rates and claims processing for services provided during the calendar year two years prior to the year in which notification is provided. If the commissioner and federally qualified health center or rural health clinic do not mutually agree to close out these rates and claims processing within 90 days following the commissioner's notification, the matter shall be submitted to an arbiter to determine whether to extend the closeout deadline.

Sec. 21. Minnesota Statutes 2012, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) ~~Effective July 1, 2007,~~ The commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c). ~~Effective September 1, 2011, the commissioner shall apply for matching funds for expenditures in paragraph (c).~~

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:.

~~(1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;~~

~~(2) based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27; and~~

~~(3)~~ By May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

~~(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:~~

~~(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:~~

~~(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and~~

~~(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and~~

~~(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.~~

~~(d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. These funds shall be made available as the state share of payments under section 256.969, subdivision 28. The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.~~

~~(e)~~ (c) For services provided on or after September 1, 2011, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the MinnesotaCare program ~~according to the requirements and conditions of paragraph (c)~~. A hospital may elect on an annual basis to not be a disproportionate

share hospital for purposes of this paragraph, if the hospital does not qualify for a payment under section 256.969, subdivision 9, paragraph (b).

Sec. 22. **REPEALER.**

Minnesota Statutes 2012, sections 256.969, subdivisions 8b, 9a, 9b, 11, 13, 20, 21, 22, 25, 26, 27, and 28; and 256.9695, subdivisions 3 and 4, are repealed.

ARTICLE 3

NORTHSTAR CARE FOR CHILDREN

Section 1. Minnesota Statutes 2012, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints.** (a) Except as provided in paragraph (c), for any background study completed under this chapter, when the commissioner has reasonable cause to believe that further pertinent information may exist on the subject of the background study, the subject shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

(b) For purposes of requiring fingerprints, the commissioner has reasonable cause when, but not limited to, the:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined; or

(3) commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

(c) Except as specified under section 245C.04, subdivision 1, paragraph (d), for background studies conducted by the commissioner for child foster care ~~or~~, adoptions, or a transfer of permanent legal and physical custody of a child, the subject of the background study, who is 18 years of age or older, shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

Sec. 2. Minnesota Statutes 2013 Supplement, section 245C.08, subdivision 1, is amended to read:

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

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

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

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

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

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

(6) for a background study related to a child foster care application for licensure, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years; and

(ii) information from national crime information databases, when the background study subject is 18 years of age or older.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

Sec. 3. Minnesota Statutes 2012, section 245C.33, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by commissioner.** (a) Before placement of a child for purposes of adoption, the commissioner shall conduct a background study on individuals listed in ~~section~~ sections 259.41, subdivision 3, and 260C.611, for county agencies and private agencies licensed to place children for adoption. When a prospective adoptive parent is seeking to adopt a child who is currently placed in

the prospective adoptive parent's home and is under the guardianship of the commissioner according to section 260C.325, subdivision 1, paragraph (b), and the prospective adoptive parent holds a child foster care license, a new background study is not required when:

(1) a background study was completed on persons required to be studied under section 245C.03 in connection with the application for child foster care licensure after July 1, 2007;

(2) the background study included a review of the information in section 245C.08, subdivisions 1, 3, and 4; and

(3) as a result of the background study, the individual was either not disqualified or, if disqualified, the disqualification was set aside under section 245C.22, or a variance was issued under section 245C.30.

(b) Before the kinship placement agreement is signed for the purpose of transferring permanent legal and physical custody to a relative under sections 260C.503 to 260C.515, the commissioner shall conduct a background study on each person age 13 or older living in the home. When a prospective relative custodian has a child foster care license, a new background study is not required when:

(1) a background study was completed on persons required to be studied under section 245C.03 in connection with the application for child foster care licensure after July 1, 2007;

(2) the background study included a review of the information in section 245C.08, subdivisions 1, 3, and 4; and

(3) as a result of the background study, the individual was either not disqualified or, if disqualified, the disqualification was set aside under section 245C.22, or a variance was issued under section 245C.30. The commissioner and the county agency shall expedite any request for a set aside or variance for a background study required under chapter 256N.

Sec. 4. Minnesota Statutes 2012, section 245C.33, subdivision 4, is amended to read:

Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review the following information regarding the background study subject:

(1) the information under section 245C.08, subdivisions 1, 3, and 4;

(2) information from the child abuse and neglect registry for any state in which the subject has resided for the past five years; and

(3) information from national crime information databases, when required under section 245C.08.

(b) The commissioner shall provide any information collected under this subdivision to the county or private agency that initiated the background study. The commissioner shall also provide the agency:

(1) notice whether the information collected shows that the subject of the background study has a conviction listed in United States Code, title 42, section 671(a)(20)(A); and

(2) for background studies conducted under subdivision 1, paragraph (a), the date of all adoption-related background studies completed on the subject by the commissioner after June 30, 2007, and the name of the county or private agency that initiated the adoption-related background study.

Sec. 5. Minnesota Statutes 2013 Supplement, section 256B.055, subdivision 1, is amended to read:

Subdivision 1. **Children eligible for subsidized adoption assistance.** Medical assistance may be paid for a child eligible for or receiving adoption assistance payments under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and to any child who is not title IV-E eligible but who was determined eligible for adoption assistance under chapter 256N or section 259A.10, subdivision 2, and has a special need for medical or rehabilitative care.

Sec. 6. Minnesota Statutes 2013 Supplement, section 256N.02, is amended by adding a subdivision to read:

Subd. 14a. **Licensed child foster parent.** "Licensed child foster parent" means a person who is licensed for child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or licensed by a Minnesota tribe in accordance with tribal standards.

Sec. 7. Minnesota Statutes 2013 Supplement, section 256N.21, subdivision 2, is amended to read:

Subd. 2. **Placement in foster care.** To be eligible for foster care benefits under this section, the child must be in placement away from the child's legal parent ~~or~~, guardian, or Indian custodian as defined in section 260.755, subdivision 10, and ~~all of the following criteria must be met~~ must meet one of the criteria in clause (1) and either clause (2) or (3):

~~(1) the legally responsible agency must have placement authority and care responsibility, including for a child 18 years old or older and under age 21, who maintains eligibility for foster care consistent with section 260C.451;~~

~~(2)~~ (1) the legally responsible agency must have placement authority to place the child with: (i) a voluntary placement agreement or a court order, consistent with sections 260B.198, 260C.001, and 260D.01, or ~~continued eligibility~~ consistent with section 260C.451 for a child 18 years old or older and under age 21 who maintains eligibility for

foster care; or (ii) a voluntary placement agreement or court order by a Minnesota tribe that is consistent with United States Code, title 42, section 672(a)(2); and

~~(3)~~ (2) the child ~~must be~~ is placed ~~in an emergency relative placement under section 245A.035,~~ with a licensed ~~foster family setting, foster residence setting, or treatment foster care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, a family foster home licensed or approved by a tribal agency or, for a child 18 years old or older and under age 21,~~ child foster parent; or

(3) the child is placed in one of the following unlicensed child foster care settings:

(i) an emergency relative placement under tribal licensing regulations or section 245A.035, with the legally responsible agency ensuring the relative completes the required child foster care application process;

(ii) a licensed adult foster home with an approved age variance under section 245A.16 for no more than six months;

(iii) for a child 18 years old or older and under age 21 who is eligible for extended foster care under section 260C.451, an unlicensed supervised independent living setting approved by the agency responsible for the ~~youth's~~ child's care.; or

(iv) a preadoptive placement in a home specified in section 245A.03, subdivision 2, paragraph (a), clause (9), with an approved adoption home study and signed adoption placement agreement.

Sec. 8. Minnesota Statutes 2013 Supplement, section 256N.21, is amended by adding a subdivision to read:

Subd. 7. **Background study.** (a) A county or private agency conducting a background study for purposes of child foster care licensing or approval must conduct the study in accordance with chapter 245C and must meet the requirements in United States Code, title 42, section 671(a)(20).

(b) A Minnesota tribe conducting a background study for purposes of child foster care licensing or approval must conduct the study in accordance with the requirements in United States Code, title 42, section 671(a)(20), when applicable.

Sec. 9. Minnesota Statutes 2013 Supplement, section 256N.22, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) To be eligible for guardianship assistance under this section, there must be a judicial determination under section 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to a relative is in the child's best interest. For a child under jurisdiction of a tribal court, a

judicial determination under a similar provision in tribal code indicating that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood, and that this is in the child's best interest is considered equivalent. Additionally, a child must:

(1) have been removed from the child's home pursuant to a voluntary placement agreement or court order;

(2)(i) have resided ~~in~~ with the prospective relative custodian who has been a licensed child foster ~~care~~ parent for at least six consecutive months ~~in the home of the prospective relative custodian~~; or

(ii) have received from the commissioner an exemption from the requirement in item (i) ~~from the court~~ that the prospective relative custodian has been a licensed child foster parent for at least six consecutive months, based on a determination that:

(A) an expedited move to permanency is in the child's best interest;

(B) expedited permanency cannot be completed without provision of guardianship assistance; ~~and~~

(C) the prospective relative custodian is uniquely qualified to meet the child's needs, as defined in section 260C.212, subdivision 2, on a permanent basis;

(D) the child and prospective relative custodian meet the eligibility requirements of this section; and

(E) efforts were made by the legally responsible agency to place the child with the prospective relative custodian as a licensed child foster parent for six consecutive months before permanency, or an explanation why these efforts were not in the child's best interests;

(3) meet the agency determinations regarding permanency requirements in subdivision 2;

(4) meet the applicable citizenship and immigration requirements in subdivision 3;

(5) have been consulted regarding the proposed transfer of permanent legal and physical custody to a relative, if the child is at least 14 years of age or is expected to attain 14 years of age prior to the transfer of permanent legal and physical custody; and

(6) have a written, binding agreement under section 256N.25 among the caregiver or caregivers, the financially responsible agency, and the commissioner established prior to transfer of permanent legal and physical custody.

(b) In addition to the requirements in paragraph (a), the child's prospective relative custodian or custodians must meet the applicable background study requirements in subdivision 4.

(c) To be eligible for title IV-E guardianship assistance, a child must also meet any additional criteria in section 473(d) of the Social Security Act. The sibling of a child who meets the criteria for title IV-E guardianship assistance in section 473(d) of the Social Security Act is eligible for title IV-E guardianship assistance if the child and sibling are placed with the same prospective relative custodian or custodians, and the legally responsible agency, relatives, and commissioner agree on the appropriateness of the arrangement for the sibling. A child who meets all eligibility criteria except those specific to title IV-E guardianship assistance is entitled to guardianship assistance paid through funds other than title IV-E.

Sec. 10. Minnesota Statutes 2013 Supplement, section 256N.22, subdivision 2, is amended to read:

Subd. 2. **Agency determinations regarding permanency.** (a) To be eligible for guardianship assistance, the legally responsible agency must complete the following determinations regarding permanency for the child prior to the transfer of permanent legal and physical custody:

(1) a determination that reunification and adoption are not appropriate permanency options for the child; and

(2) a determination that the child demonstrates a strong attachment to the prospective relative custodian and the prospective relative custodian has a strong commitment to caring permanently for the child.

(b) The legally responsible agency shall document the determinations in paragraph (a) and ~~the~~ eligibility requirements in this section that comply with United States Code, title 42, sections 673(d) and 675(1)(F). These determinations must be documented in a kinship placement agreement, which must be in the format prescribed by the commissioner and must be signed by the prospective relative custodian and the legally responsible agency. In the case of a Minnesota tribe, the determinations and eligibility requirements in this section may be provided in an alternative format approved by the commissioner. Supporting information for completing each determination must be documented in the legally responsible agency's case file and ~~make them~~ available for review as requested by the financially responsible agency and the commissioner during the guardianship assistance eligibility determination process.

Sec. 11. Minnesota Statutes 2013 Supplement, section 256N.22, subdivision 4, is amended to read:

Subd. 4. **Background study.** (a) A background study ~~under section 245C.33~~ must be completed on each prospective relative custodian and any other adult residing in the home of the prospective relative custodian. The background study must meet the requirements of United States Code, title 42, section 671(a)(20). A study completed under section 245C.33 meets this requirement. A background study on the prospective relative custodian or adult residing in the household previously completed under ~~section 245C.04~~ chapter 245C for the purposes of child foster care licensure ~~may~~ under chapter 245A or licensure by a Minnesota tribe, shall be used for the purposes of this section, provided that the background study ~~is current~~ meets the requirements of this subdivision and the prospective relative custodian is a licensed child foster parent at the time of the application for guardianship assistance.

(b) If the background study reveals:

(1) a felony conviction at any time for:

(i) child abuse or neglect;

(ii) spousal abuse;

(iii) a crime against a child, including child pornography; or

(iv) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(2) a felony conviction within the past five years for:

(i) physical assault;

(ii) battery; or

(iii) a drug-related offense;

the prospective relative custodian is prohibited from receiving guardianship assistance on behalf of an otherwise eligible child.

Sec. 12. Minnesota Statutes 2013 Supplement, section 256N.22, subdivision 6, is amended to read:

Subd. 6. **Exclusions.** (a) A child with a guardianship assistance agreement under Northstar Care for Children is not eligible for the Minnesota family investment program child-only grant under chapter 256J.

(b) The commissioner shall not enter into a guardianship assistance agreement with:

(1) a child's biological parent or stepparent;

(2) an individual assuming permanent legal and physical custody of a child or the equivalent under tribal code without involvement of the child welfare system; or

(3) an individual assuming permanent legal and physical custody of a child who was placed in Minnesota by another state or a tribe outside of Minnesota.

Sec. 13. Minnesota Statutes 2013 Supplement, section 256N.23, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) To be eligible for Northstar adoption assistance under this section, a child must:

(1) be determined to be a child with special needs under subdivision 2;

(2) meet the applicable citizenship and immigration requirements in subdivision 3;

(3)(i) meet the criteria in section 473 of the Social Security Act; or

(ii) have had foster care payments paid on the child's behalf while in out-of-home placement through the county social service agency or ~~tribe and be either under the~~ tribal social service agency prior to the issuance of a court order transferring the child's guardianship ~~of~~ to the commissioner or ~~under the jurisdiction of a Minnesota tribe and adoption, according to tribal law, is in the child's documented permanency plan~~ making the child a ward of the tribe; and

(4) have a written, binding agreement under section 256N.25 among the adoptive parent, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, and the commissioner established prior to finalization of the adoption.

(b) In addition to the requirements in paragraph (a), an eligible child's adoptive parent or parents must meet the applicable background study requirements in subdivision 4.

(c) A child who meets all eligibility criteria except those specific to title IV-E adoption assistance shall receive adoption assistance paid through funds other than title IV-E.

(d) A child receiving Northstar kinship assistance payments under section 256N.22 is eligible for Northstar adoption assistance when the criteria in paragraph (a) are met and the child's legal custodian is adopting the child.

Sec. 14. Minnesota Statutes 2013 Supplement, section 256N.23, subdivision 4, is amended to read:

Subd. 4. **Background study.** (a) A background study ~~under section 259.41~~ must be completed on each prospective adoptive parent. and all other adults residing in the home. A background study must meet the requirements of United States Code, title 42, section 671(a)(20). A study completed under section 245C.33 meets this requirement. If the prospective adoptive parent is a licensed child foster parent licensed under chapter 245A or by a Minnesota tribe, the background study previously completed for the purposes of child foster care licensure shall be used for the purpose of this section, provided that the background study meets all other requirements of this subdivision and the prospective

adoptive parent is a licensed child foster parent at the time of the application for adoption assistance.

(b) If the background study reveals:

(1) a felony conviction at any time for:

(i) child abuse or neglect;

(ii) spousal abuse;

(iii) a crime against a child, including child pornography; or

(iv) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(2) a felony conviction within the past five years for:

(i) physical assault;

(ii) battery; or

(iii) a drug-related offense;

the adoptive parent is prohibited from receiving adoption assistance on behalf of an otherwise eligible child.

Sec. 15. Minnesota Statutes 2013 Supplement, section 256N.24, subdivision 9, is amended to read:

Subd. 9. **Timing of and requests for reassessments.** Reassessments for an eligible child must be completed within 30 days of any of the following events:

(1) for a child in continuous foster care, when six months have elapsed since ~~completion of the last assessment~~ the initial assessment, and annually thereafter;

(2) for a child in continuous foster care, change of placement location;

(3) for a child in foster care, at the request of the financially responsible agency or legally responsible agency;

(4) at the request of the commissioner; or

(5) at the request of the caregiver under subdivision ~~9~~ 10.

Sec. 16. Minnesota Statutes 2013 Supplement, section 256N.24, subdivision 10, is amended to read:

Subd. 10. **Caregiver requests for reassessments.** (a) A caregiver may initiate a reassessment request for an eligible child in writing to the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner. The written request must include the reason for the request and the name, address, and contact information of the caregivers. ~~For an eligible child with a guardianship assistance or adoption assistance agreement,~~ The caregiver may request a

reassessment if at least six months have elapsed since any ~~previously requested review~~ previous assessment or reassessment. ~~For an eligible foster child, a foster parent may request reassessment in less than six months with written documentation that there have been significant changes in the child's needs that necessitate an earlier reassessment.~~

(b) A caregiver may request a reassessment of an at-risk child for whom ~~a guardianship assistance or~~ an adoption assistance agreement has been executed if the caregiver has satisfied the commissioner with written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself, consistent with section 256N.25, subdivision 3, paragraph (b).

(c) If the reassessment cannot be completed within 30 days of the caregiver's request, the agency responsible for reassessment must notify the caregiver of the reason for the delay and a reasonable estimate of when the reassessment can be completed.

(d) Notwithstanding any provision to the contrary in paragraph (a) or subdivision 9, when a Northstar kinship assistance agreement or adoption assistance agreement under section 256N.25 has been signed by all parties, no reassessment may be requested or conducted until the court finalizes the transfer of permanent legal and physical custody or finalizes the adoption, or the assistance agreement expires according to section 256N.25, subdivision 1.

Sec. 17. Minnesota Statutes 2013 Supplement, section 256N.25, subdivision 2, is amended to read:

Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible for guardianship assistance or adoption assistance, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, must negotiate with the caregiver to develop an agreement under subdivision 1. If and when the caregiver and agency reach concurrence as to the terms of the agreement, both parties shall sign the agreement. The agency must submit the agreement, along with the eligibility determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to the commissioner for final review, approval, and signature according to subdivision 1.

(b) A monthly payment is provided as part of the adoption assistance or guardianship assistance agreement to support the care of children unless the child is eligible for adoption assistance and determined to be an at-risk child, in which case ~~the special at-risk monthly payment under section 256N.26, subdivision 7, must~~ no payment will be made unless and until the caregiver obtains written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself.

(1) The amount of the payment made on behalf of a child eligible for guardianship assistance or adoption assistance is determined through agreement between the prospective relative custodian or the adoptive parent and the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the associated benefit and payments outlined in section 256N.26. Except as provided under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes the monthly benefit level for a child under foster care. The monthly payment under a guardianship assistance agreement or adoption assistance agreement may be negotiated up to the monthly benefit level under foster care. In no case may the amount of the payment under a guardianship assistance agreement or adoption assistance agreement exceed the foster care maintenance payment which would have been paid during the month if the child with respect to whom the guardianship assistance or adoption assistance payment is made had been in a foster family home in the state.

(2) The rate schedule for the agreement is determined based on the age of the child on the date that the prospective adoptive parent or parents or relative custodian or custodians sign the agreement.

(3) The income of the relative custodian or custodians or adoptive parent or parents must not be taken into consideration when determining eligibility for guardianship assistance or adoption assistance or the amount of the payments under section 256N.26.

(4) With the concurrence of the relative custodian or adoptive parent, the amount of the payment may be adjusted periodically using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under subdivision 3 when there is a change in the child's needs or the family's circumstances.

(5) ~~The guardianship assistance or adoption assistance agreement of a child who is identified as at-risk receives the special at-risk monthly payment under section 256N.26, subdivision 7, unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly. A relative custodian or~~ An adoptive parent of an at-risk child with ~~a guardianship assistance or~~ an adoption assistance agreement may request a reassessment of the child under section 256N.24, subdivision ~~9~~ 10, and renegotiation of the ~~guardianship assistance or~~ adoption assistance agreement under subdivision 3 to include a monthly payment, if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner.

(c) For guardianship assistance agreements:

(1) the initial amount of the monthly guardianship assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed less any offsets under section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to by the prospective relative custodian and specified in that agreement, unless ~~the child is identified as at-risk or~~ the guardianship assistance agreement is entered into when a child is under the age of six; and

~~(2) an at-risk child must be assigned level A as outlined in section 256N.26 and receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless and until the potential disability manifests itself, as documented by a qualified expert, and the commissioner authorizes commencement of payment by modifying the agreement accordingly; and~~

~~(3)~~ (2) the amount of the monthly payment for a guardianship assistance agreement for a child~~, other than an at-risk child,~~ who is under the age of six must be as specified in section 256N.26, subdivision 5.

(d) For adoption assistance agreements:

(1) for a child in foster care with the prospective adoptive parent immediately prior to adoptive placement, the initial amount of the monthly adoption assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed less any offsets in section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to by the prospective adoptive parents and specified in that agreement, unless the child is identified as at-risk or the adoption assistance agreement is entered into when a child is under the age of six;

(2) for an at-risk child who must be assigned level A as outlined in section 256N.26 ~~and receive the special at-risk monthly payment under section 256N.26, subdivision 7~~, no payment will be made unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly;

(3) the amount of the monthly payment for an adoption assistance agreement for a child under the age of six, other than an at-risk child, must be as specified in section 256N.26, subdivision 5;

(4) for a child who is in the guardianship assistance program immediately prior to adoptive placement, the initial amount of the adoption assistance payment must be equivalent to the guardianship assistance payment in effect at the time that the adoption assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive parent and specified in that agreement, unless the child is identified as an at-risk child; and

(5) for a child who is not in foster care placement or the guardianship assistance program immediately prior to adoptive placement or negotiation of the adoption assistance agreement, the initial amount of the adoption assistance agreement must be determined using the assessment tool and process in this section and the corresponding payment amount outlined in section 256N.26.

Sec. 18. Minnesota Statutes 2013 Supplement, section 256N.25, subdivision 3, is amended to read:

Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive parent of a child with a guardianship assistance or adoption assistance agreement may request renegotiation of the agreement when there is a change in the needs of the child or in the family's circumstances. When a relative custodian or adoptive parent requests renegotiation of the agreement, a reassessment of the child must be completed consistent with section 256N.24, subdivisions 9 and 10. If the reassessment indicates that the child's level has changed, the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner or the commissioner's designee, and the caregiver must renegotiate the agreement to include a payment with the level determined through the reassessment process. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(b) ~~A relative custodian or~~ An adoptive parent of an at-risk child with ~~a guardianship assistance or~~ an adoption assistance agreement may request renegotiation of the agreement to include a monthly payment ~~higher than the special at-risk monthly payment~~ under section 256N.26~~, subdivision 7,~~ if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment of the child must be conducted as outlined in section 256N.24, subdivision 9. The reassessment must be used to renegotiate the agreement to include an appropriate monthly payment. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(c) Renegotiation of a guardianship assistance or adoption assistance agreement is required when one of the circumstances outlined in section 256N.26, subdivision 13, occurs.

Sec. 19. Minnesota Statutes 2013 Supplement, section 256N.26, subdivision 1, is amended to read:

Subdivision 1. **Benefits.** (a) There are three benefits under Northstar Care for Children: medical assistance, basic payment, and supplemental difficulty of care payment.

(b) A child is eligible for medical assistance under subdivision 2.

(c) A child is eligible for the basic payment under subdivision 3, except for a child assigned level A under section 256N.24, subdivision 1, because the child is determined to be an at-risk child receiving ~~guardianship assistance or~~ adoption assistance.

(d) A child, including a foster child age 18 to 21, is eligible for an additional supplemental difficulty of care payment under subdivision 4, as determined by the assessment under section 256N.24.

(e) An eligible child entering guardianship assistance or adoption assistance under the age of six receives a basic payment and supplemental difficulty of care payment as specified in subdivision 5.

(f) A child transitioning in from a pre-Northstar Care for Children program under section 256N.28, subdivision 7, shall receive basic and difficulty of care supplemental payments according to those provisions.

Sec. 20. Minnesota Statutes 2013 Supplement, section 256N.27, subdivision 4, is amended to read:

Subd. 4. **Nonfederal share.** (a) The commissioner shall establish a percentage share of the maintenance payments, reduced by federal reimbursements under title IV-E of the Social Security Act, to be paid by the state and to be paid by the financially responsible agency.

(b) These state and local shares must initially be calculated based on the ratio of the average appropriate expenditures made by the state and all financially responsible agencies during calendar years 2011, 2012, 2013, and 2014. For purposes of this calculation, appropriate expenditures for the financially responsible agencies must include basic and difficulty of care payments for foster care reduced by federal reimbursements, but not including any initial clothing allowance, administrative payments to child care agencies specified in section 317A.907, child care, or other support or ancillary expenditures. For purposes of this calculation, appropriate expenditures for the state shall include adoption assistance and relative custody assistance, reduced by federal reimbursements.

(c) For each of the periods January 1, 2015, to June 30, 2016, and fiscal years 2017, 2018, and 2019, the commissioner shall adjust this initial percentage of state and local shares to reflect the relative expenditure trends during calendar years 2011, 2012, 2013, and

2014, taking into account appropriations for Northstar Care for Children and the turnover rates of the components. In making these adjustments, the commissioner's goal shall be to make these state and local expenditures other than the appropriations for Northstar Care for Children to be the same as they would have been had Northstar Care for Children not been implemented, or if that is not possible, proportionally higher or lower, as appropriate. Except for adjustments so that the costs of the phase-in are borne by the state, the state and local share percentages for fiscal year 2019 must be used for all subsequent years.

Sec. 21. Minnesota Statutes 2012, section 257.85, subdivision 11, is amended to read:

Subd. 11. **Financial considerations.** (a) Payment of relative custody assistance under a relative custody assistance agreement is subject to the availability of state funds and payments may be reduced or suspended on order of the commissioner if insufficient funds are available.

(b) ~~Upon receipt from a local agency of a claim for reimbursement, the commissioner shall reimburse the local agency in an amount equal to 100 percent of the relative custody assistance payments provided to relative custodians. The~~ A local agency may not seek and the commissioner shall not provide reimbursement for the administrative costs associated with performing the duties described in subdivision 4.

(c) For the purposes of determining eligibility or payment amounts under MFIP, relative custody assistance payments shall be excluded in determining the family's available income.

(d) For expenditures made on or before December 31, 2014, upon receipt from a local agency of a claim for reimbursement, the commissioner shall reimburse the local agency in an amount equal to 100 percent of the relative custody assistance payments provided to relative custodians.

(e) For expenditures made on or after January 1, 2015, upon receipt from a local agency of a claim for reimbursement, the commissioner shall reimburse the local agency as part of the Northstar Care for Children fiscal reconciliation process under section 256N.27.

Sec. 22. Minnesota Statutes 2012, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** (a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in foster care by court order or a voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.

(b) An out-of-home placement plan means a written document which is prepared by the responsible social services agency jointly with the parent or parents or guardian

of the child and in consultation with the child's guardian ad litem, the child's tribe, if the child is an Indian child, the child's foster parent or representative of the foster care facility, and, where appropriate, the child. For a child in voluntary foster care for treatment under chapter 260D, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

(2) ordered by the court, either as presented or modified after hearing, under section 260C.178, subdivision 7, or 260C.201, subdivision 6; and

(3) signed by the parent or parents or guardian of the child, the child's guardian ad litem, a representative of the child's tribe, the responsible social services agency, and, if possible, the child.

(c) The out-of-home placement plan shall be explained to all persons involved in its implementation, including the child who has signed the plan, and shall set forth:

(1) a description of the foster care home or facility selected, including how the out-of-home placement plan is designed to achieve a safe placement for the child in the least restrictive, most family-like, setting available which is in close proximity to the home of the parent or parents or guardian of the child when the case plan goal is reunification, and how the placement is consistent with the best interests and special needs of the child according to the factors under subdivision 2, paragraph (b);

(2) the specific reasons for the placement of the child in foster care, and when reunification is the plan, a description of the problems or conditions in the home of the parent or parents which necessitated removal of the child from home and the changes the parent or parents must make in order for the child to safely return home;

(3) a description of the services offered and provided to prevent removal of the child from the home and to reunify the family including:

(i) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (2), and the time period during which the actions are to be taken; and

(ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made to achieve a safe and stable home for the child including social and other supportive services to be provided or offered to the parent or parents or guardian of the child, the child, and the residential facility during the period the child is in the residential facility;

(4) a description of any services or resources that were requested by the child or the child's parent, guardian, foster parent, or custodian since the date of the child's placement in the residential facility, and whether those services or resources were provided and if not, the basis for the denial of the services or resources;

(5) the visitation plan for the parent or parents or guardian, other relatives as defined in section 260C.007, subdivision 27, and siblings of the child if the siblings are not placed together in foster care, and whether visitation is consistent with the best interest of the child, during the period the child is in foster care;

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize the permanency plan for the child, including:

(i) reasonable efforts to place the child for adoption ~~or legal guardianship of the child if the court has issued an order terminating the rights of both parents of the child or of the only known, living parent of the child~~. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child, child-specific recruitment efforts such as relative search and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b); and

(ii) documentation necessary to support the requirements of the kinship placement agreement under section 256N.22 when adoption is determined not to be in the child's best interest;

(7) efforts to ensure the child's educational stability while in foster care, including:

(i) efforts to ensure that the child remains in the same school in which the child was enrolled prior to placement or upon the child's move from one placement to another, including efforts to work with the local education authorities to ensure the child's educational stability; or

(ii) if it is not in the child's best interest to remain in the same school that the child was enrolled in prior to placement or move from one placement to another, efforts to ensure immediate and appropriate enrollment for the child in a new school;

(8) the educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) a statement about how the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement; and

(v) any other relevant educational information;

(9) the efforts by the local agency to ensure the oversight and continuity of health care services for the foster child, including:

(i) the plan to schedule the child's initial health screens;

(ii) how the child's known medical problems and identified needs from the screens, including any known communicable diseases, as defined in section 144.4172, subdivision 2, will be monitored and treated while the child is in foster care;

(iii) how the child's medical information will be updated and shared, including the child's immunizations;

(iv) who is responsible to coordinate and respond to the child's health care needs, including the role of the parent, the agency, and the foster parent;

(v) who is responsible for oversight of the child's prescription medications;

(vi) how physicians or other appropriate medical and nonmedical professionals will be consulted and involved in assessing the health and well-being of the child and determine the appropriate medical treatment for the child; and

(vii) the responsibility to ensure that the child has access to medical care through either medical insurance or medical assistance;

(10) the health records of the child including information available regarding:

(i) the names and addresses of the child's health care and dental care providers;

(ii) a record of the child's immunizations;

(iii) the child's known medical problems, including any known communicable diseases as defined in section 144.4172, subdivision 2;

(iv) the child's medications; and

(v) any other relevant health care information such as the child's eligibility for medical insurance or medical assistance;

(11) an independent living plan for a child age 16 or older. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management, including the responsibility of the agency to ensure that the youth annually receives, at no cost to the youth, a consumer report as defined under section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;

(v) planning for housing;

(vi) social and recreational skills; and

(vii) establishing and maintaining connections with the child's family and community; and

(12) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes.

(d) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

Upon discharge from foster care, the parent, adoptive parent, or permanent legal and physical custodian, as appropriate, and the child, if appropriate, must be provided with a current copy of the child's health and education record.

Sec. 23. Minnesota Statutes 2012, section 260C.515, subdivision 4, is amended to read:

Subd. 4. **Custody to relative.** The court may order permanent legal and physical custody to a fit and willing relative in the best interests of the child according to the following ~~conditions~~ requirements:

(1) an order for transfer of permanent legal and physical custody to a relative shall only be made after the court has reviewed the suitability of the prospective legal and physical custodian;

(2) in transferring permanent legal and physical custody to a relative, the juvenile court shall follow the standards applicable under this chapter and chapter 260, and the procedures in the Minnesota Rules of Juvenile Protection Procedure;

(3) a transfer of legal and physical custody includes responsibility for the protection, education, care, and control of the child and decision making on behalf of the child;

(4) a permanent legal and physical custodian may not return a child to the permanent care of a parent from whom the court removed custody without the court's approval and without notice to the responsible social services agency;

(5) the social services agency may file a petition naming a fit and willing relative as a proposed permanent legal and physical custodian. A petition for transfer of permanent legal and physical custody to a relative who is not a parent shall be accompanied by a

kinship placement agreement under section 256N.22, subdivision 2, between the agency and proposed permanent legal and physical custodian;

(6) another party to the permanency proceeding regarding the child may file a petition to transfer permanent legal and physical custody to a relative~~, but the~~. The petition must include facts upon which the court can make the determination required under clause (7) and must be filed not later than the date for the required admit-deny hearing under section 260C.507; or if the agency's petition is filed under section 260C.503, subdivision 2, the petition must be filed not later than 30 days prior to the trial required under section 260C.509; ~~and~~

(7) where a petition is for transfer of permanent legal and physical custody to a relative who is not a parent, the court must find that:

(i) transfer of permanent legal and physical custody and receipt of Northstar kinship assistance under chapter 256N, when requested and the child is eligible, is in the child's best interests;

(ii) adoption is not in the child's best interests based on the determinations in the kinship placement agreement required under section 256N.22, subdivision 2;

(iii) the agency made efforts to discuss adoption with the child's parent or parents, or the agency did not make efforts to discuss adoption and the reasons why efforts were not made; and

(iv) there are reasons to separate siblings during placement, if applicable;

(8) the court may defer finalization of an order transferring permanent legal and physical custody to a relative when deferring finalization is necessary to determine eligibility for Northstar kinship assistance under chapter 256N;

(9) the court may finalize a permanent transfer of physical and legal custody to a relative regardless of eligibility for Northstar kinship assistance under chapter 256N; and

~~(7)~~ (10) the juvenile court may maintain jurisdiction over the responsible social services agency, the parents or guardian of the child, the child, and the permanent legal and physical custodian for purposes of ensuring appropriate services are delivered to the child and permanent legal custodian for the purpose of ensuring conditions ordered by the court related to the care and custody of the child are met.

Sec. 24. Minnesota Statutes 2012, section 260C.611, is amended to read:

260C.611 ADOPTION STUDY REQUIRED.

(a) An adoption study under section 259.41 approving placement of the child in the home of the prospective adoptive parent shall be completed before placing any child under the guardianship of the commissioner in a home for adoption. If a prospective adoptive

parent has a current child foster care license under chapter 245A and is seeking to adopt a foster child who is placed in the prospective adoptive parent's home and is under the guardianship of the commissioner according to section 260C.325, subdivision 1, the child foster care home study meets the requirements of this section for an approved adoption home study if:

(1) the written home study on which the foster care license was based is completed in the commissioner's designated format, consistent with the requirements in sections 260C.215, subdivision 4, clause (5); and 259.41, subdivision 2; and Minnesota Rules, part 2960.3060, subpart 4;

(2) the background studies on each prospective adoptive parent and all required household members were completed according to section 245C.33;

(3) the commissioner has not issued, within the last three years, a sanction on the license under section 245A.07 or an order of a conditional license under section 245A.06; and

(4) the legally responsible agency determines that the individual needs of the child are being met by the prospective adoptive parent through an assessment under section 256N.24, subdivision 2, or a documented placement decision consistent with section 260C.212, subdivision 2.

(b) If a prospective adoptive parent has previously held a foster care license or adoptive home study, any update necessary to the foster care license, or updated or new adoptive home study, if not completed by the licensing authority responsible for the previous license or home study, shall include collateral information from the previous licensing or approving agency, if available.

Sec. 25. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the term "guardianship assistance" to "Northstar kinship assistance" wherever it appears in Minnesota Statutes and Minnesota Rules to refer to the program components related to Northstar Care for Children under Minnesota Statutes, chapter 256N.

Sec. 26. **REPEALER.**

Minnesota Statutes 2013 Supplement, section 256N.26, subdivision 7, is repealed.

ARTICLE 4

COMMUNITY FIRST SERVICES AND SUPPORTS

Section 1. Minnesota Statutes 2012, section 245C.03, is amended by adding a subdivision to read:

Subd. 8. **Community first services and supports organizations.** The commissioner shall conduct background studies on any individual required under section 256B.85 to have a background study completed under this chapter.

Sec. 2. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision to read:

Subd. 7. **Community first services and supports organizations.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 8, at least upon application for initial enrollment under section 256B.85.

(b) Before an individual described in section 245C.03, subdivision 8, begins a position allowing direct contact with a person served by an organization required to initiate a background study under section 256B.85, the organization must receive a notice from the commissioner that the support worker is:

(1) not disqualified under section 245C.14; or

(2) disqualified, but the individual has received a set-aside of the disqualification under section 245C.22.

Sec. 3. Minnesota Statutes 2012, section 245C.10, is amended by adding a subdivision to read:

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services contractor providing service functions under section 256B.85, subdivision 13, through a fee of no more than $20 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 4. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 2, is amended to read:

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

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

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

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating. "Level I behavior" means physical aggression towards self or others or destruction of property that requires the immediate response of another person. If qualified for a home care rating as described in subdivision 8, additional service units can be added as described in subdivision 8, paragraph (f), for the following behaviors:

(1) Level I behavior;

(2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(3) increased need for assistance for ~~recipients~~ participants who are verbally aggressive or resistive to care so that time needed to perform activities of daily living is increased.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a vendor fiscal/employer agent financial management services (FMS) contractor for a participant to directly employ support workers and purchase supports and goods.

~~(e)~~ (f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

~~(f)~~ (g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, ~~paragraph (a),~~ clause (3), that replace the need for human assistance.

~~(g)~~ (h) "Community first services and supports service delivery plan" or "service delivery plan" means a written ~~summary of~~ document detailing the services and supports

chosen by the participant to meet assessed needs that ~~is~~ are within the approved CFSS service authorization amount. Services and supports are based on the community support plan identified in section 256B.0911 and coordinated services and support plan and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined by the participant to meet the assessed needs, using a person-centered planning process.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that is under contract with the department and has the knowledge, skills, and ability to assist CFSS participants in using either the agency-provider model under subdivision 11 or the budget model under subdivision 13.

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

~~(i)~~ (k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child may not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

~~(j)~~ (l) "Extended CFSS" means CFSS services and supports under the agency-provider model included in a service plan through one of the home and community-based services waivers and approved and authorized under sections 256B.0915; 256B.092, subdivision 5; and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.

~~(k)~~ (m) "Financial management services contractor or vendor" or "FMS contractor" means a qualified organization ~~having~~ necessary to use the budget model under subdivision 13 that has a written contract with the department to provide vendor fiscal/employer agent financial management services ~~necessary to use the budget model under subdivision 13 that~~ (FMS). Services include but are not limited to: ~~participant education and technical assistance; CFSS service delivery planning and budgeting;~~ filing and payment of federal and state payroll taxes on behalf of the participant; initiating criminal background checks; billing~~, making payments, and~~ for approved CFSS funds; monitoring ~~of spending~~ expenditures; accounting and disbursing CFSS funds; providing assistance in obtaining liability, workers' compensation, and unemployment coverage and filings; and ~~assisting~~ participant instruction and technical assistance to the participant in fulfilling employer-related requirements in accordance with Section 3504 of the Internal Revenue

Code and ~~the Internal Revenue Service Revenue Procedure 70-6~~ related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1.

~~(l) "Budget model" means a service delivery method of CFSS that allows the use of an individualized CFSS service delivery plan and service budget and provides assistance from the financial management services contractor to facilitate participant employment of support workers and the acquisition of supports and goods.~~

~~(m)~~ (n) "Health-related procedures and tasks" means procedures and tasks related to the specific needs of an individual that can be ~~delegated~~ taught or assigned by a state-licensed healthcare or mental health professional and performed by a support worker.

~~(n)~~ (o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

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

~~(p)~~ (q) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker may not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

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

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

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

~~(q)~~ (r) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant to serve as a representative in connection with the provision of CFSS. This authorization must be in writing or by another method that clearly indicates the participant's free choice. The participant's representative must

have no financial interest in the provision of any services included in the participant's service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is determined to be in need of a participant's representative, one must be selected. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:

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

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

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

~~(r)~~ (s) "Person-centered planning process" means a process that is directed by the participant to plan for services and supports. The person-centered planning process must:

(1) include people chosen by the participant;

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

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

(4) reflect cultural considerations of the participant;

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

(6) provide the participant choices of the services and supports they receive and the staff providing those services and supports;

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

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

~~(s)~~ (t) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by the same ~~provider~~ agency-provider.

~~(t) "Support specialist" means a professional with the skills and ability to assist the participant using either the agency-provider model under subdivision 11 or the flexible~~

~~spending model under subdivision 13, in services including but not limited to assistance regarding:~~

~~(1) the development, implementation, and evaluation of the CFSS service delivery plan under subdivision 6;~~

~~(2) recruitment, training, or supervision, including supervision of health-related tasks or behavioral supports appropriately delegated or assigned by a health care professional, and evaluation of support workers; and~~

~~(3) facilitating the use of informal and community supports, goods, or resources.~~

(u) "Support worker" means ~~an~~ a qualified and trained employee of the ~~agency provider~~ agency-provider or of the participant employer under the budget model who has direct contact with the participant and provides services as specified within the participant's service delivery plan.

(v) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(w) "Worker training and development" means services for developing workers' skills as required by the participant's individual CFSS delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Sec. 5. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

(1) is ~~a recipient~~ an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

(2) is a ~~recipient of~~ participant in the alternative care program under section 256B.0913;

(3) is a waiver ~~recipient~~ participant as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a participant's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a ~~recipient of~~ participant under a family support grant under section 252.32~~;~~.

~~(3) lives in the person's own apartment or home including a family foster care setting licensed under chapter 245A, but not in corporate foster care under chapter 245A; or a noncertified boarding care home or a boarding and lodging establishment under chapter 157.~~

Sec. 6. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivision 3a;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant; and

(3) be completed using the format established by the commissioner.

~~(b) A participant who is residing in a facility may be assessed and choose CFSS for the purpose of using CFSS to return to the community as described in subdivisions 3 and 7, paragraph (a), clause (5).~~

~~(c)~~ (b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's certified assessor as defined in section 256B.0911 to the participant and the agency-provider or ~~financial management services provider~~ FMS contractor chosen by the participant within 40 calendar days and must include the participant's right to appeal under section 256.045, subdivision 3.

~~(d)~~ (c) The lead agency assessor may ~~request~~ authorize a temporary authorization for CFSS services to be provided under the agency-provider model. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this ~~provision~~ paragraph shall have no bearing on a future authorization.

Sec. 7. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 6, is amended to read:

Subd. 6. **Community first services and support service delivery plan.** (a) The CFSS service delivery plan must be developed~~, implemented,~~ and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a ~~support specialist~~ consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the community support plan under section 256B.0911, subdivision 3, or the coordinated services and support plan identified in section 256B.0915, subdivision 6, if applicable. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or ~~financial management services~~ FMS contractor prior to starting services and at least annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

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

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

(1) specify the consultation services provider, agency-provider, or ~~financial management services~~ FMS contractor selected by the participant;

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

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

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

(5) include individually identified goals and desired outcomes;

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

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

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

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

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

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

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

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

(14) include a detailed budget for expenditures for budget model participants or participants under the agency-provider model if purchasing goods; and

(15) include a plan for worker training and development detailing what service components will be used, when the service components will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

(d) The total units of agency-provider services or the service budget ~~allocation~~ amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service authorization. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount unless a change in condition is assessed and authorized by the certified assessor and documented in the community support plan, coordinated services and supports plan, and CFSS service delivery plan.

(e) In assisting with the development or modification of the plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS contractor on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager/care coordinator.

(f) The service plan must be approved by the consultation services provider for participants without a case manager/care coordinator. A case manager/care coordinator must approve the plan for a waiver or alternative care program participant.

Sec. 8. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Within the service unit authorization or service budget ~~allocation~~ amount, services and supports covered under CFSS include:

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

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

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

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

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

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

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

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

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

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

~~(6) transition costs, including:~~

~~(i) deposits for rent and utilities;~~

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

~~(iii) bedding;~~

~~(iv) basic kitchen supplies;~~

~~(v) other necessities, to the extent that these necessities are not otherwise covered under any other funding that the participant is eligible to receive; and~~

~~(vi) other required necessities for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for persons with developmental disabilities to a community-based home setting where the participant resides; and~~

~~(7)~~ (6) services provided by a ~~support specialist~~ consultation services provider under contract with the department and defined under subdivision ~~2 that are chosen by the participant.~~ 17;

(7) services provided by an FMS contractor under contract with the department as defined under subdivision 13;

(8) CFSS services that may be provided by a qualified support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. These support workers shall not provide any medical assistance home

and community-based services in excess of 40 hours per seven-day period regardless of the number of parents, combination of parents and spouses, or number of children who receive medical assistance services; and

(9) worker training and development services as defined in subdivision 2, paragraph (w), and described in subdivision 18a.

Sec. 9. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service methodology.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin, except for the assessments established in section 256B.0911. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the ~~recipient's~~ participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the ~~person~~ participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a ~~recipient~~ participant:

(1) the total number of dependencies of activities of daily living as defined in subdivision 2, paragraph (b);

(2) the presence of complex health-related needs as defined in subdivision 2, paragraph (e); and

(3) the presence of Level I behavior as defined in subdivision 2, paragraph (d)~~, clause (1)~~.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs and qualifies one for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies one for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies one for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies one for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies one for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies one for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies one for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies one for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies one for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). ~~Recipients~~ Participants who meet the definition of ventilator-dependent and the EN home care rating and utilize a combination of CFSS and other home care services are limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a ~~recipient's~~ participant's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in subdivision 2, paragraph ~~(h)~~ (j);

(2) 30 additional minutes per day for each complex health-related function as defined in subdivision 2, paragraph ~~(e)~~ (f); and

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

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) a multiplier established by the commissioner for administrative expenses.

Sec. 10. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 9, is amended to read:

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

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

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

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

(4) supplant natural unpaid supports that appropriately meet a need in the service plan, are provided voluntarily to the participant, and are selected by the participant in lieu of other services and supports;

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

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

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

(1) those that are not for the direct benefit of the participant, except that services for caregivers such as training to improve the ability to provide CFSS are considered to directly benefit the participant if chosen by the participant and approved in the support plan;

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

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

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

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

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

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

(8) medical supplies and equipment;

(9) environmental modifications, except as specified in subdivision 7;

(10) expenses for travel, lodging, or meals related to training the participant~~,~~ or the participant's representative~~,~~ or legal representative~~, or paid or unpaid caregivers that exceed $500 in a 12-month period~~;

(11) experimental treatments;

(12) any service or good covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(13) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. The condition must be identified in the participant's CFSS plan and monitored by a physician enrolled in a Minnesota health care program;

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

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

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

(17) instrumental activities of daily living for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to CFSS services and the assessor has listed the need in the service plan;

(18) services provided and billed by a provider who is not an enrolled CFSS provider;

(19) CFSS provided by a participant's representative or paid legal guardian;

(20) services that are used solely as a child care or babysitting service;

(21) services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;

(22) sterile procedures;

(23) giving of injections into veins, muscles, or skin;

(24) homemaker services that are not an integral part of the assessed CFSS service;

(25) home maintenance or chore services;

(26) home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant;

(27) services to other members of the participant's household;

(28) services not specified as covered under medical assistance as CFSS;

(29) application of restraints or implementation of deprivation procedures;

(30) assessments by CFSS provider organizations or by independently enrolled registered nurses;

(31) services provided in lieu of legally required staffing in a residential or child care setting; and

(32) services provided by the residential or program license holder in a residence for more than four persons.

Sec. 11. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 10, is amended to read:

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

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

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

~~(3)~~ (2) demonstrate compliance with ~~law~~ federal and state laws and policies ~~of~~ for CFSS as determined by the commissioner;

~~(4)~~ (3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results;

~~(5)~~ (4) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers ~~and support specialists~~;

~~(6)~~ (5) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family members, or participants' representatives;

(6) directly provide services and not use a subcontractor or reporting agent;

(7) meet the financial requirements established by the commissioner for financial solvency;

(8) have never had a lead agency contract or provider agreement discontinued due to fraud, or have never had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider;

(9) have established business practices that include written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality CFSS; and

(10) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and VF/EA financial management services contractors shall:

~~(7)~~ (1) pay support workers ~~and support specialists~~ based upon actual hours of services provided;

(2) pay for worker training and development services based upon actual hours of services provided or the unit cost of the training session purchased;

~~(8)~~ (3) withhold and pay all applicable federal and state payroll taxes;

~~(9)~~ (4) make arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

~~(10)~~ (5) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided using a format established by the commissioner;

~~(11)~~ (6) report maltreatment as required under sections 626.556 and 626.557; ~~and~~

~~(12)~~ (7) provide the participant with a copy of the service-related rights under subdivision 20 at the start of services and supports~~.~~; and

(8) comply with any data requests from the department.

Sec. 12. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 11, is amended to read:

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

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

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

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

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

(f) The agency-provider model must be used by individuals who have been restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under this model, along with support worker services, must:

(1) specify the goods in the service delivery plan and detailed budget for expenditures that must be approved by the consultation services provider or the case manager/care coordinator; and

(2) use the FMS contractor for the billing and payment of such goods.

Sec. 13. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 12, is amended to read:

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

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

(2) proof of surety bond coverage. Upon new enrollment, or if the ~~provider agency's~~ agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the ~~provider agency~~ agency-provider must purchase a performance bond of $50,000. If the ~~provider agency's~~ agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the ~~provider agency~~ agency-provider must purchase a performance bond of $100,000. The performance bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

(7) a copy of the CFSS ~~provider agency's~~ agency-provider's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the CFSS ~~provider agency~~ agency-provider uses in the course of daily business including, but not limited to:

(i) a copy of the CFSS ~~provider agency's~~ agency-provider's time sheet if the time sheet varies from the standard time sheet for CFSS services approved by the commissioner, and a letter requesting approval of the CFSS ~~provider agency's~~ agency-provider's nonstandard time sheet; and

(ii) ~~the~~ a copy of the participant's individual CFSS ~~provider agency's template for the CFSS care~~ service delivery plan;

(9) a list of all training and classes that the CFSS ~~provider agency~~ agency-provider requires of its staff providing CFSS services;

(10) documentation that the CFSS ~~provider agency~~ agency-provider and staff have successfully completed all the training required by this section;

(11) documentation of the ~~agency's~~ agency-provider's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the ~~agency~~ agency-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for ~~employee personal care assistant~~ CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers. The revenue generated by the ~~support specialist~~ worker training and development services and the reasonable costs associated with the ~~support specialist~~ worker training and development services shall not be used in making this calculation; and

(14) documentation that the ~~agency~~ agency-provider does not burden ~~recipients'~~ participants' free exercise of their right to choose service providers by requiring ~~personal care assistants~~ CFSS support workers to sign an agreement not to work with any particular CFSS ~~recipient~~ participant or for another CFSS ~~provider agency~~ agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS ~~provider agencies~~ agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS ~~provider agencies~~ agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS ~~provider agency~~ agency-provider do

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

(d) The commissioner shall send annual review notifications to agency-providers 30 days prior to renewal. The notification must:

(1) list the materials and information the agency-provider is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information.

Agency-providers shall submit the required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the agency-provider enrollment number must be terminated or suspended.

Sec. 14. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 13, is amended to read:

Subd. 13. **Budget model.** (a) Under the budget model participants ~~can~~ may exercise more responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use services provided by an FMS contractor as defined in subdivision 2, paragraph (m). Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7~~; and~~.

~~(3) choose a range of support assistance services from the financial management services (FMS) contractor related to:~~

~~(i) assistance in managing the budget to meet the service delivery plan needs, consistent with federal and state laws and regulations;~~

~~(ii) the employment, training, supervision, and evaluation of workers by the participant;~~

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

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

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

(c) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under the following circumstances that include but are not limited to:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative cannot manage participant responsibilities under the budget model. The commissioner must develop policies for determining if a participant is unable to manage responsibilities under the budget model.

(d) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph (c), clause (3), to disenroll or exclude the participant from the budget model.

~~(c)~~ (e) The FMS contractor shall not provide CFSS services and supports under the agency-provider service model.

(f) The FMS contractor shall provide service functions as determined by the commissioner for budget model participants that include but are not limited to:

~~(1) information and consultation about CFSS;~~

~~(2)~~ (1) assistance with the development of the detailed budget for expenditures portion of the service delivery plan ~~and budget model~~ as requested by the consultation services provider or participant;

~~(3)~~ (2) billing and making payments for budget model expenditures;

~~(4)~~ (3) assisting participants in fulfilling employer-related requirements according to ~~Internal Revenue Service Revenue Procedure 70-6, section 3504, Agency Employer Tax Liability, regulation 137036-08~~ section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, which includes assistance with filing and paying payroll taxes, and obtaining worker compensation coverage;

~~(5)~~ (4) data recording and reporting of participant spending; ~~and~~

~~(6)~~ (5) other duties established in the contract with the department, including with respect to providing assistance to the participant, participant's representative, or legal

representative in performing their employer responsibilities regarding support workers. The support worker shall not be considered the employee of the ~~financial management services~~ FMS contractor~~.~~; and

(6) billing, payment, and accounting of approved expenditures for goods for agency-provider participants.

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

~~(e)~~ (g) The FMS contractor shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models consistent with any applicable state and federal requirements;

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

(3) be knowledgeable of state and federal employment regulations, including those under the Fair Labor Standards Act of 1938, and comply with the requirements under ~~the Internal Revenue Service Revenue Procedure 70-6, Section 3504,~~ section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability for vendor or fiscal employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

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

(5) assume fiscal accountability for state funds designated for the program and be held liable for any overpayments or violations of applicable statutes or rules, including but not limited to the Minnesota False Claims Act; and

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

~~spending~~ service budget and service plan and must contain specific identifying information as determined by the commissioner.

~~(f)~~ (h) The commissioner of human services shall:

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

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

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

~~(g) The commissioner of human services shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under the following circumstances that include but are not limited to:~~

~~(1) when a participant has been restricted by the Minnesota restricted recipient program, the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;~~

~~(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or~~

~~(3) when the department determines that the participant or participant's representative or legal representative cannot manage participant responsibilities under the budget model. The commissioner must develop policies for determining if a participant is unable to manage responsibilities under a budget model.~~

~~(h) A participant may appeal under section 256.045, subdivision 3, in writing to the department to contest the department's decision under paragraph (c), clause (3), to remove or exclude the participant from the budget model.~~

Sec. 15. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 15, is amended to read:

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

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

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

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

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

(3) full name of the participant;

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

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

(6) personal signature of the support worker;

(7) any shared care provided, if applicable;

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

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

Sec. 16. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 16, is amended to read:

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

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

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

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

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

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

(4) not be a participant of CFSS, unless the support services provided by the support worker differ from those provided to the support worker;

(5) complete the basic standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

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

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

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

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

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

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

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

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

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

(d) A support worker must not provide or be paid for more than 275 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

Sec. 17. Minnesota Statutes 2013 Supplement, section 256B.85, is amended by adding a subdivision to read:

Subd. 16a. **Exception to support worker requirements.** The support worker for a participant may be allowed to enroll with a different CFSS agency-provider or FMS contractor upon initiation of a new background study according to chapter 245C, if the following conditions are met:

(1) the commissioner determines that the support worker's change in enrollment or affiliation is needed to ensure continuity of services and protect the health and safety of the participant;

(2) the chosen agency-provider or FMS contractor has been continuously enrolled as a CFSS agency-provider or FMS contractor for at least two years or since the inception of the CFSS program, whichever is shorter;

(3) the participant served by the support worker chooses to transfer to the CFSS agency-provider or the FMS contractor to which the support worker is transferring;

(4) the support worker has been continuously enrolled with the former CFSS agency-provider or FMS contractor since the support worker's last background study was completed; and

(5) the support worker continues to meet requirements of subdivision 16, excluding paragraph (a), clause (1).

Sec. 18. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 17, is amended to read:

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

(a) Consultation services means providing assistance to the participant in making informed choices regarding CFSS services in general and self-directed tasks in particular and in developing a person-centered service delivery plan to achieve quality service outcomes.

(b) Consultation services is a required service that may include but is not limited to:

(1) an initial and annual orientation to CFSS information and policies, including selecting a service model;

(2) assistance with the development, implementation, management, and evaluation of the person-centered service delivery plan;

(3) consultation on recruiting, selecting, training, managing, directing, evaluating, and supervising support workers;

(4) reviewing the use of and access to informal and community supports, goods, or resources;

(5) remediation support; and

(6) assistance with accessing FMS contractors or agency-providers.

(c) Duties of a consultation services provider shall include but are not limited to:

(1) review and finalization of the CFSS service delivery plan by the consultation services provider organization;

(2) distribution of copies of the final service delivery plan to the participant and to the agency-provider or FMS contractor, case manager/care coordinator, and other designated parties;

(3) an evaluation of services upon receiving information from an FMS contractor indicating spending or participant employer concerns;

(4) a biannual review of services if the participant does not have a case manager/care coordinator and when the support worker is a paid parent of a minor participant or the participant's spouse;

(5) collection and reporting of data as required by the department; and

(6) providing the participant with a copy of the service-related rights under subdivision 20 at the start of consultation services.

Sec. 19. Minnesota Statutes 2013 Supplement, section 256B.85, is amended by adding a subdivision to read:

Subd. 17a. **Consultation service provider qualifications and requirements.** The commissioner shall develop the qualifications and requirements for providers of consultation services under subdivision 17. These providers must satisfy at least the following qualifications and requirements:

(1) are under contract with the department;

(2) are not the FMS contractor as defined in subdivision 2, paragraph (m), the CFSS or HCBS waiver agency-provider or vendor to the participant, or a lead agency;

(3) meet the service standards as established by the commissioner;

(4) employ lead professional staff with a minimum of three years' experience in providing support planning, support broker, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(5) are knowledgeable about CFSS roles and responsibilities including those of the certified assessor, FMS contractor, agency-provider, and case manager/care coordinator;

(6) comply with medical assistance provider requirements;

(7) understand the CFSS program and its policies;

(8) are knowledgeable about self-directed principles and the application of the person-centered planning process;

(9) have general knowledge of the FMS contractor duties and participant employment model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

(10) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

Sec. 20. Minnesota Statutes 2013 Supplement, section 256B.85, is amended by adding a subdivision to read:

Subd. 17b. **Financial management services and consultation services payment methodology.** The commissioner shall establish a cost-neutral funding mechanism for FMS and consultation services.

Sec. 21. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 18, is amended to read:

Subd. 18. **Service unit and budget allocation requirements and limits.** (a) For the agency-provider model, services will be authorized in units of service. The total service unit amount must be established based upon the assessed need for CFSS services, and must not exceed the maximum number of units available as determined under subdivision 8.

(b) For the budget model, the service budget allocation allowed for services and supports is ~~established by multiplying the number of units authorized under subdivision 8 by the payment rate established by the commissioner~~ defined in subdivision 8, paragraph (g).

Sec. 22. Minnesota Statutes 2013 Supplement, section 256B.85, is amended by adding a subdivision to read:

Subd. 18a. **Worker training and development services.** (a) The commissioner shall develop the scope of tasks and functions, service standards, and service limits for worker training and development services.

(b) Worker training and development services are in addition to the participant's assessed service units or service budget. Services provided according to this subdivision must:

(1) help support workers obtain and expand the skills and knowledge necessary to ensure competency in providing quality services as needed and defined in the participant's service delivery plan;

(2) be provided or arranged for by the agency-provider under subdivision 11 or purchased by the participant employer under the budget model under subdivision 13; and

(3) be described in the participant's CFSS service delivery plan and documented in the participant's file.

(c) Services covered under worker training and development shall include:

(1) support worker training on the participant's individual assessed needs, condition, or both, provided individually or in a group setting by a skilled and knowledgeable trainer beyond any training the participant or participant's representative provides;

(2) tuition for professional classes and workshops for the participant's support workers that relate to the participant's assessed needs, condition, or both;

(3) direct observation, monitoring, coaching, and documentation of support worker job skills and tasks, beyond any training the participant or participant's representative provides, including supervision of health-related tasks or behavioral supports that is conducted by an appropriate professional based on the participant's assessed needs. These services must be provided within 14 days of the start of services or the start of a new support worker and must be specified in the participant's service delivery plan; and

(4) reporting service and support concerns to the appropriate provider.

(d) Worker training and development services shall not include:

(1) general agency training, worker orientation, or training on CFSS self-directed models;

(2) payment for preparation or development time for the trainer or presenter;

(3) payment of the support worker's salary or compensation during the training;

(4) training or supervision provided by the participant, the participant's support worker, or the participant's informal supports, including the participant's representative; or

(5) services in excess of 96 units per annual service authorization, unless approved by the department.

Sec. 23. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 23, is amended to read:

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

Sec. 24. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 24, is amended to read:

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

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

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

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

(2) a background study must be initiated and completed for all ~~support specialists~~ staff providing worker training and development employed by the agency-provider; and

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

Sec. 25. Laws 2013, chapter 108, article 7, section 49, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective upon federal approval but no earlier than April 1, 2014. The service will begin 90 days after federal approval ~~or April 1, 2014, whichever is later~~. The commissioner of human services shall notify the revisor of statutes when this occurs.

ARTICLE 5

CONTINUING CARE

Section 1. Minnesota Statutes 2012, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) When a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is responsible for

maltreatment under section 626.556 or 626.557, the identity of the applicant or license holder as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is disqualified under chapter 245C, the identity of the license holder or applicant as the disqualified individual and the reason for the disqualification are public data at the time of the issuance of the licensing sanction or denial. If the applicant or license holder requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data.

(2) Notwithstanding sections 626.556, subdivision 11, and 626.557, subdivision 12b, when any person subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home is a substantiated perpetrator of maltreatment, and the substantiated maltreatment is a reason for a licensing action, the identity of the substantiated perpetrator of maltreatment is public data. For purposes of this clause, a person is a substantiated perpetrator if the maltreatment determination has been upheld under section 256.045; 626.556, subdivision 10i; 626.557, subdivision 9d; or chapter 14, or if an individual or facility has not timely exercised appeal rights under these sections, except as provided under clause (1).

(3) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(4) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(5) The following data on persons subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section

245C.22, subdivisions 2 and 4, and the reasons for setting aside the disqualification; the nature of any disqualification for which a variance was granted under sections 245A.04, subdivision 9; and 245C.30, and the reasons for granting any variance under section 245A.04, subdivision 9; and, if applicable, the disclosure that any person subject to a background study under section 245C.03, subdivision 1, has successfully passed a background study. If a licensing sanction under section 245A.07, or a license denial under section 245A.05, is based on a determination that an individual subject to disqualification under chapter 245C is disqualified, the disqualification as a basis for the licensing sanction or denial is public data. As specified in clause (1), item (iv), if the disqualified individual is the license holder or applicant, the identity of the license holder or applicant and the reason for the disqualification are public data; and, if the license holder or applicant requested reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data. If the disqualified individual is an individual other than the license holder or applicant, the identity of the disqualified individual shall remain private data.

(6) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(7) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment under sections 626.556 and 626.557, are confidential data and may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the Department of Health for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, data on individuals collected by the commissioner of human services according to investigations under chapters 245A, 245B, ~~and~~ 245C, and 245D, and sections 626.556 and 626.557 may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the

individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 2. Minnesota Statutes 2013 Supplement, section 245.8251, is amended to read:

245.8251 POSITIVE SUPPORT STRATEGIES AND EMERGENCY MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.

Subdivision 1. **Rules governing the use of positive support strategies and restricting or prohibiting aversive and deprivation procedures.** The commissioner of human services shall, ~~within 24 months of May 23, 2013~~ by August 31, 2015, adopt rules governing the use of positive support strategies, ~~safety interventions, and~~ emergency use of manual restraint, and restricting or prohibiting the use of aversive and deprivation procedures, in all facilities and services licensed under chapter 245D~~.~~ and in all licensed facilities and licensed services serving persons with a developmental disability or related condition. For the purposes of this section, "developmental disability or related condition" has the meaning given in Minnesota Rules, part 9525.0016, subpart 2, items A to E.

Subd. 2. **Data collection.** (a) The commissioner shall, with stakeholder input, ~~develop~~ identify data ~~collection~~ elements specific to incidents of emergency use of manual restraint and positive support transition plans for persons receiving services from ~~providers governed~~ licensed facilities and licensed services under chapter 245D and in licensed facilities and licensed services serving persons with a developmental disability or related condition as defined in Minnesota Rules, part 9525.0016, subpart 2, effective January 1, 2014. ~~Providers~~ Licensed facilities and licensed services shall report the data in a format and at a frequency determined by the commissioner of human services~~. Providers shall submit the data~~ to the commissioner and the Office of the Ombudsman for Mental Health and Developmental Disabilities.

(b) Beginning July 1, 2013, ~~providers~~ licensed facilities and licensed services regulated under Minnesota Rules, parts 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures identified in Minnesota Rules, part 9525.2740, in a format and at a frequency determined by the commissioner~~. Providers~~

~~shall submit the data~~ to the commissioner and the Office of the Ombudsman for Mental Health and Developmental Disabilities.

Subd. 3. **External program review committee.** Rules adopted according to this section shall establish requirements for an external program review committee appointed by the commissioner to monitor the rules after adoption of the rules.

Subd. 4. **Interim review panel.** (a) The commissioner shall establish an interim review panel by August 15, 2014, for the purpose of reviewing requests for emergency use of procedures that have been part of an approved positive support transition plan when necessary to protect a person from imminent risk of serious injury as defined in section 245.91, subdivision 6, due to self-injurious behavior. The panel must make recommendations to the commissioner to approve or deny these requests based on criteria to be established by the interim review panel. The interim review panel shall operate until the external program review committee is established as required under subdivision 3.

(b) Members of the interim review panel shall be selected based on their expertise and knowledge related to the use of positive support strategies as alternatives to the use of aversive or deprivation procedures. The commissioner shall seek input and recommendations from the Office of the Ombudsman for Mental Health and Developmental Disabilities and the Minnesota Governor's Council on Developmental Disabilities in establishing the interim review panel. Members of the interim review panel shall include the following representatives:

(1) an expert in positive supports;

(2) a mental health professional, as defined in section 245.462;

(3) a licensed health professional as defined in section 245D.02, subdivision 14;

(4) a representative of the Department of Health;

(5) a representative of the Office of the Ombudsman for Mental Health and Developmental Disabilities; and

(6) a representative of the Minnesota Disability Law Center.

Sec. 3. Minnesota Statutes 2013 Supplement, section 245A.042, subdivision 3, is amended to read:

Subd. 3. **Implementation.** (a) The commissioner shall implement the responsibilities of this chapter according to the timelines in paragraphs (b) and (c) only within the limits of available appropriations or other administrative cost recovery methodology.

(b) The licensure of home and community-based services according to this section shall be implemented January 1, 2014. License applications shall be received and

processed on a phased-in schedule as determined by the commissioner beginning July 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that the application is complete according to section 245A.04.

(c) Within the limits of available appropriations or other administrative cost recovery methodology, implementation of compliance monitoring must be phased in after January 1, 2014.

(1) Applicants who do not currently hold a license issued under chapter 245B must receive an initial compliance monitoring visit after 12 months of the effective date of the initial license for the purpose of providing technical assistance on how to achieve and maintain compliance with the applicable law or rules governing the provision of home and community-based services under chapter 245D. If during the review the commissioner finds that the license holder has failed to achieve compliance with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing review report with recommendations for achieving and maintaining compliance.

(2) Applicants who do currently hold a license issued under this chapter must receive a compliance monitoring visit after 24 months of the effective date of the initial license.

(d) Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend or revoke a license or issue a fine at any time under section 245A.07, or issue correction orders and make a license conditional for failure to comply with applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

(e) License holders governed under chapter 245D must ensure compliance with the following requirements within the stated timelines:

(1) service initiation and service planning requirements must be met at the next annual meeting of the person's support team or by January 1, 2015, whichever is later, for the following:

(i) provision of a written notice that identifies the service recipient rights and an explanation of those rights as required under section 245D.04, subdivision 1;

(ii) service planning for basic support services as required under section 245D.07, subdivision 2; and

(iii) service planning for intensive support services under section 245D.071, subdivisions 3 and 4;

(2) staff orientation to program requirements as required under section 245D.09, subdivision 4, for staff hired before January 1, 2014, must be met by January 1, 2015.

The license holder may otherwise provide documentation verifying these requirements were met before January 1, 2014;

(3) development of policy and procedures as required under section 245D.11, must be completed no later than August 31, 2014;

(4) written notice and copies of policies and procedures must be provided to all persons or their legal representatives and case managers as required under section 245D.10, subdivision 4, paragraphs (b) and (c), by September 15, 2014, or within 30 days of development of the required policies and procedures, whichever is earlier; and

(5) all employees must be informed of the revisions and training must be provided on implementation of the revised policies and procedures as required under section 245D.10, subdivision 4, paragraph (d), by September 15, 2014, or within 30 days of development of the required policies and procedures, whichever is earlier.

Sec. 4. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 3, is amended to read:

Subd. 3. **Case manager.** "Case manager" means the individual designated to provide waiver case management services, care coordination, or long-term care consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions. For purposes of this chapter, "case manager" includes case management services as defined in Minnesota Rules, part 9520.0902, subpart 3.

Sec. 5. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 4b, is amended to read:

Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions. For purposes of this chapter, "coordinated service and support plan" includes the individual program plan or individual treatment plan as defined in Minnesota Rules, part 9520.0510, subpart 12.

Sec. 6. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 8b, is amended to read:

Subd. 8b. **Expanded support team.** "Expanded support team" means the members of the support team defined in subdivision ~~46~~ 34 and a licensed health or mental health professional or other licensed, certified, or qualified professionals or consultants working

with the person and included in the team at the request of the person or the person's legal representative.

Sec. 7. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 11, is amended to read:

Subd. 11. **Incident.** "Incident" means an occurrence which involves a person and requires the program to make a response that is not a part of the program's ordinary provision of services to that person, and includes:

(1) serious injury of a person as determined by section 245.91, subdivision 6;

(2) a person's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911, physician treatment, or hospitalization;

(4) any mental health crisis that requires the program to call 911 ~~or~~, a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate;

(5) an act or situation involving a person that requires the program to call 911, law enforcement, or the fire department;

(6) a person's unauthorized or unexplained absence from a program;

(7) conduct by a person receiving services against another person receiving services that:

(i) is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;

(ii) places the person in actual and reasonable fear of harm;

(iii) places the person in actual and reasonable fear of damage to property of the person; or

(iv) substantially disrupts the orderly operation of the program;

(8) any sexual activity between persons receiving services involving force or coercion as defined under section 609.341, subdivisions 3 and 14;

(9) any emergency use of manual restraint as identified in section 245D.061; or

(10) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.556 or 626.557.

Sec. 8. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 15b, is amended to read:

Subd. 15b. **Mechanical restraint.** (a) ~~Except for devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement, or the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition,~~ "Mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term applies to the use of mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury.

(b) Mechanical restraint does not include the following:

(1) devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement; or

(2) the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition.

Sec. 9. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 29, is amended to read:

Subd. 29. **Seclusion.** "Seclusion" means ~~the placement of a person alone in~~: (1) removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room~~.~~; or (2) otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return.

Sec. 10. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 34, is amended to read:

Subd. 34. **Support team.** "Support team" means the service planning team identified in section 256B.49, subdivision 15~~, or~~, the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14; or the case management team as defined in Minnesota Rules, part 9520.0902, subpart 6.

Sec. 11. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 34a, is amended to read:

Subd. 34a. **Time out.** "Time out" means ~~removing a person involuntarily from an ongoing activity to a room, either locked or unlocked, or otherwise separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if the person chooses~~ the involuntary removal of a person for a period of time to a designated area from which the person is not prevented from leaving. For the purpose of this chapter, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior ~~for a period of up to 15 minutes. "Time out" does not include a person voluntarily moving from an ongoing activity to an unlocked room or otherwise separating from a situation or social contact with others if the person chooses. For the purposes of this definition, "voluntarily" means without being forced, compelled, or coerced.~~; nor does it mean taking a brief "break" or "rest" from an activity for the purpose of providing the person an opportunity to regain self-control. For the purpose of this subdivision, "brief" means a duration of three minutes or less.

Sec. 12. Minnesota Statutes 2013 Supplement, section 245D.02, is amended by adding a subdivision to read:

Subd. 35b. **Unlicensed staff.** "Unlicensed staff" means individuals not otherwise licensed or certified by a governmental health board or agency.

Sec. 13. Minnesota Statutes 2013 Supplement, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and safety of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community alternatives for disabled individuals, developmental disability, and elderly waiver plans;

(2) adult companion services as defined under the brain injury, community alternatives for disabled individuals, and elderly waiver plans, excluding adult companion

services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community alternatives for disabled individuals and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan; and

(6) homemaker services as defined under the community alternatives for disabled individuals, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and safety of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) behavioral support services as defined under the brain injury and community alternatives for disabled individuals waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community alternatives for disabled individuals waiver plans; and

(iii) semi-independent living services;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community alternatives for disabled individuals waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; and

(iii) residential services provided to more than four persons with developmental disabilities in a supervised living facility ~~that is certified by the Department of Health as an ICF/DD~~, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.40 to 252.46, and as defined under the developmental disability waiver plan; and

(iii) prevocational services as defined under the brain injury and community alternatives for disabled individuals waiver plans; and

(5) supported employment as defined under the brain injury, developmental disability, and community alternatives for disabled individuals waiver plans.

Sec. 14. Minnesota Statutes 2013 Supplement, section 245D.03, is amended by adding a subdivision to read:

Subd. 1a. **Effect.** The home and community-based services standards establish health, safety, welfare, and rights protections for persons receiving services governed by this chapter. The standards recognize the diversity of persons receiving these services and require that these services are provided in a manner that meets each person's individual needs and ensures continuity in service planning, care, and coordination between the license holder and members of each person's support team or expanded support team.

Sec. 15. Minnesota Statutes 2013 Supplement, section 245D.03, subdivision 2, is amended to read:

Subd. 2. **Relationship to other standards governing home and community-based services.** (a) A license holder governed by this chapter is also subject to the licensure requirements under chapter 245A.

(b) ~~A corporate or family child foster care site controlled by a license holder and providing services governed by this chapter is exempt from compliance with section 245D.04. This exemption applies to foster care homes where at least one resident is receiving residential supports and services licensed according to this chapter.~~ This chapter does not apply to corporate or family child foster care homes that do not provide services licensed under this chapter.

(c) A family adult foster care site controlled by a license holder ~~and~~ providing services governed by this chapter is exempt from compliance with Minnesota Rules, parts 9555.6185; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265. These exemptions apply to family adult foster care homes where at least one resident is receiving

residential supports and services licensed according to this chapter. This chapter does not apply to family adult foster care homes that do not provide services licensed under this chapter.

(d) A license holder providing services licensed according to this chapter in a supervised living facility is exempt from compliance with ~~sections~~ section 245D.04~~; 245D.05, subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5)~~.

(e) A license holder providing residential services to persons in an ICF/DD is exempt from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09, subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

(f) A license holder providing homemaker services licensed according to this chapter and registered according to chapter 144A is exempt from compliance with section 245D.04.

(g) Nothing in this chapter prohibits a license holder from concurrently serving persons without disabilities or people who are or are not age 65 and older, provided this chapter's standards are met as well as other relevant standards.

(h) The documentation required under sections 245D.07 and 245D.071 must meet the individual program plan requirements identified in section 256B.092 or successor provisions.

Sec. 16. Minnesota Statutes 2013 Supplement, section 245D.03, subdivision 3, is amended to read:

Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant a variance to any of the requirements in this chapter, except sections 245D.04; 245D.06, subdivision 4, paragraph (b), and subdivision 6; and ~~245D.061, subdivision 3, or~~ provisions governing data practices and information rights of persons.

Sec. 17. Minnesota Statutes 2013 Supplement, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, ~~or~~ seclusion, or any aversive, deprivation, or other prohibited procedure identified in section 245D.06, subdivision 5, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section ~~245D.06;~~ 245D.061; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice;

(14) personal privacy; and

(15) engage in chosen activities.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence; and

(4) privacy for visits with the person's spouse, next of kin, legal counsel, religious advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom.

(c) Restriction of a person's rights under ~~subdivision 2, clause (10), or~~ paragraph (a), clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

Sec. 18. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 1, is amended to read:

Subdivision 1. **Health needs.** (a) The license holder is responsible for meeting health service needs assigned in the coordinated service and support plan or the coordinated service and support plan addendum, consistent with the person's health needs. The license holder is responsible for promptly notifying the person's legal representative, if any, and the case manager of changes in a person's physical and mental health needs affecting health service needs assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, when discovered by the license holder, unless the license holder has reason to know the change has already been reported. The license holder must document when the notice is provided.

(b) If responsibility for meeting the person's health service needs has been assigned to the license holder in the coordinated service and support plan or the coordinated service

and support plan addendum, the license holder must maintain documentation on how the person's health needs will be met, including a description of the procedures the license holder will follow in order to:

(1) provide medication setup, assistance, or ~~medication~~ administration according to this chapter. Unlicensed staff responsible for medication setup or medication administration under this section must complete training according to section 245D.09, subdivision 4a, paragraph (d);

(2) monitor health conditions according to written instructions from a licensed health professional;

(3) assist with or coordinate medical, dental, and other health service appointments; or

(4) use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health professional.

Sec. 19. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 1a, is amended to read:

Subd. 1a. **Medication setup.** (a) For the purposes of this subdivision, "medication setup" means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration when the license holder is assigned responsibility ~~for medication assistance or medication administration~~ in the coordinated service and support plan or the coordinated service and support plan addendum. A prescription label or the prescriber's written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber.

(b) If responsibility for medication setup is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, or if the license holder provides it as part of medication assistance or medication administration, the license holder must document in the person's medication administration record: dates of setup, name of medication, quantity of dose, times to be administered, and route of administration at time of setup; and, when the person will be away from home, to whom the medications were given.

Sec. 20. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 1b, is amended to read:

Subd. 1b. **Medication assistance.** (a) For purposes of this subdivision, "medication assistance" means any of the following:

(1) bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person under the direction of the person;

(2) bringing to the person liquids or food to accompany the medication; or

(3) providing reminders to take regularly scheduled medication or perform regularly scheduled treatments and exercises.

(b) If responsibility for medication assistance is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must ensure that ~~the requirements of subdivision 2, paragraph (b), have been met when staff provides~~ medication assistance ~~to enable~~ is provided in a manner that enables a person to self-administer medication or treatment when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person. ~~For the purposes of this subdivision, "medication assistance" means any of the following:~~

~~(1) bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person;~~

~~(2) bringing to the person liquids or food to accompany the medication; or~~

~~(3) providing reminders to take regularly scheduled medication or perform regularly scheduled treatments and exercises.~~

Sec. 21. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 2, is amended to read:

Subd. 2. **Medication administration.** (a) ~~If responsibility for medication administration is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must implement the following medication administration procedures to ensure a person takes medications and treatments as prescribed~~ For purposes of this subdivision, "medication administration" means:

(1) checking the person's medication record;

(2) preparing the medication as necessary;

(3) administering the medication or treatment to the person;

(4) documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and

(5) reporting to the prescriber or a nurse any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to

take the medication or treatment as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

(b)(1) If responsibility for medication administration is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must implement medication administration procedures to ensure a person takes medications and treatments as prescribed. The license holder must ensure that the requirements in clauses (2) ~~to (4)~~ and (3) have been met before administering medication or treatment.

(2) The license holder must obtain written authorization from the person or the person's legal representative to administer medication or treatment and must obtain reauthorization annually as needed. This authorization shall remain in effect unless it is withdrawn in writing and may be withdrawn at any time. If the person or the person's legal representative refuses to authorize the license holder to administer medication, the medication must not be administered. The refusal to authorize medication administration must be reported to the prescriber as expediently as possible.

~~(3) The staff person responsible for administering the medication or treatment must complete medication administration training according to section 245D.09, subdivision 4a, paragraphs (a) and (c), and, as applicable to the person, paragraph (d).~~

~~(4)~~ (3) For a license holder providing intensive support services, the medication or treatment must be administered according to the license holder's medication administration policy and procedures as required under section 245D.11, subdivision 2, clause (3).

(c) The license holder must ensure the following information is documented in the person's medication administration record:

(1) the information on the current prescription label or the prescriber's current written or electronically recorded order or prescription that includes the person's name, description of the medication or treatment to be provided, and the frequency and other information needed to safely and correctly administer the medication or treatment to ensure effectiveness;

(2) information on any risks or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;

(3) the possible consequences if the medication or treatment is not taken or administered as directed;

(4) instruction on when and to whom to report the following:

(i) if a dose of medication is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person; and

(ii) the occurrence of possible adverse reactions to the medication or treatment;

(5) notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and

(6) notation of when a medication or treatment is started, administered, changed, or discontinued.

Sec. 22. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 4, is amended to read:

Subd. 4. **Reviewing and reporting medication and treatment issues.** (a) When assigned responsibility for medication administration, the license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed to identify medication administration errors. At a minimum, the review must be conducted every three months, or more frequently as directed in the coordinated service and support plan or coordinated service and support plan addendum or as requested by the person or the person's legal representative. Based on the review, the license holder must develop and implement a plan to correct patterns of medication administration errors when identified.

(b) If assigned responsibility for medication assistance or medication administration, the license holder must report the following to the person's legal representative and case manager as they occur or as otherwise directed in the coordinated service and support plan or the coordinated service and support plan addendum:

(1) any reports ~~made to the person's physician or prescriber~~ required under subdivision 2, paragraph (c), clause (4);

(2) a person's refusal or failure to take or receive medication or treatment as prescribed; or

(3) concerns about a person's self-administration of medication or treatment.

Sec. 23. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 5, is amended to read:

Subd. 5. **Injectable medications.** Injectable medications may be administered according to a prescriber's order and written instructions when one of the following conditions has been met:

(1) a registered nurse or licensed practical nurse will administer the ~~subcutaneous or intramuscular~~ injection;

(2) a supervising registered nurse with a physician's order has delegated the administration of ~~subcutaneous~~ injectable medication to an unlicensed staff member and has provided the necessary training; or

(3) there is an agreement signed by the license holder, the prescriber, and the person or the person's legal representative specifying what ~~subcutaneous~~ injections may be given, when, how, and that the prescriber must retain responsibility for the license holder's giving the injections. A copy of the agreement must be placed in the person's service recipient record.

Only licensed health professionals are allowed to administer psychotropic medications by injection.

Sec. 24. Minnesota Statutes 2013 Supplement, section 245D.051, is amended to read:

245D.051 PSYCHOTROPIC MEDICATION USE AND MONITORING.

Subdivision 1. **Conditions for psychotropic medication administration.** (a) When a person is prescribed a psychotropic medication and the license holder is assigned responsibility for administration of the medication in the person's coordinated service and support plan or the coordinated service and support plan addendum, the license holder must ensure that the requirements in ~~paragraphs (b) to (d) and~~ section 245D.05, subdivision 2, are met.

~~(b) Use of the medication must be included in the person's coordinated service and support plan or in the coordinated service and support plan addendum and based on a prescriber's current written or electronically recorded prescription.~~

~~(c)~~ (b) The license holder must develop, implement, and maintain the following documentation in the person's coordinated service and support plan addendum according to the requirements in sections 245D.07 and 245D.071:

(1) a description of the target symptoms that the psychotropic medication is to alleviate; and

(2) documentation methods the license holder will use to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medication if required by the prescriber. The license holder must collect and report on medication and symptom-related data as instructed by the prescriber. The license holder must provide the monitoring data to the expanded support team for review every three months, or as otherwise requested by the person or the person's legal representative.

For the purposes of this section, "target symptom" refers to any perceptible diagnostic criteria for a person's diagnosed mental disorder, as defined by the Diagnostic

and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) or successive editions, that has been identified for alleviation.

Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the person's legal representative refuses to authorize the administration of a psychotropic medication as ordered by the prescriber, the license holder must ~~follow the requirement in section 245D.05, subdivision 2, paragraph (b), clause (2).~~ not administer the medication. The refusal to authorize medication administration must be reported to the prescriber as expediently as possible. After reporting the refusal to the prescriber, the license holder must follow any directives or orders given by the prescriber. ~~A court order must be obtained to override the refusal.~~ A refusal may not be overridden without a court order. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A decision to terminate services must be reached in compliance with section 245D.10, subdivision 3.

Sec. 25. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 2, is amended to read:

Subd. 2. **Environment and safety.** The license holder must:

(1) ensure the following when the license holder is the owner, lessor, or tenant of the service site:

(i) the service site is a safe and hazard-free environment;

(ii) that toxic substances or dangerous items are inaccessible to persons served by the program only to protect the safety of a person receiving services when a known safety threat exists and not as a substitute for staff supervision or interactions with a person who is receiving services. If toxic substances or dangerous items are made inaccessible, the license holder must document an assessment of the physical plant, its environment, and its population identifying the risk factors which require toxic substances or dangerous items to be inaccessible and a statement of specific measures to be taken to minimize the safety risk to persons receiving services and to restore accessibility to all persons receiving services at the service site;

(iii) doors are locked from the inside to prevent a person from exiting only when necessary to protect the safety of a person receiving services and not as a substitute for staff supervision or interactions with the person. If doors are locked from the inside, the license holder must document an assessment of the physical plant, the environment and the population served, identifying the risk factors which require the use of locked doors, and a statement of specific measures to be taken to minimize the safety risk to persons receiving services at the service site; and

(iv) a staff person is available at the service site who is trained in basic first aid and, when required in a person's coordinated service and support plan or coordinated service and support plan addendum, cardiopulmonary resuscitation (CPR) whenever persons are present and staff are required to be at the site to provide direct support service. The CPR training must include in-person instruction, hands-on practice, and an observed skills assessment under the direct supervision of a CPR instructor;

(2) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition when used to provide services;

(3) follow procedures to ensure safe transportation, handling, and transfers of the person and any equipment used by the person, when the license holder is responsible for transportation of a person or a person's equipment;

(4) be prepared for emergencies and follow emergency response procedures to ensure the person's safety in an emergency; and

(5) follow universal precautions and sanitary practices, including hand washing, for infection prevention and control, and to prevent communicable diseases.

Sec. 26. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 4, is amended to read:

Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person with the safekeeping of funds or other property according to section 245A.04, subdivision 13, the license holder must obtain written authorization to do so from the person or the person's legal representative and the case manager. Authorization must be obtained within five working days of service initiation and renewed annually thereafter. At the time initial authorization is obtained, the license holder must survey, document, and implement the preferences of the person or the person's legal representative and the case manager for frequency of receiving a statement that itemizes receipts and disbursements of funds or other property. The license holder must document changes to these preferences when they are requested.

(b) A license holder or staff person may not accept powers-of-attorney from a person receiving services from the license holder for any purpose. This does not apply to license holders that are Minnesota counties or other units of government or to staff persons employed by license holders who were acting as attorney-in-fact for specific individuals prior to implementation of this chapter. The license holder must maintain documentation of the power-of-attorney in the service recipient record.

(c) A license holder or staff person is restricted from accepting an appointment as a guardian as follows:

(1) under section 524.5-309 of the Uniform Probate Code, any individual or agency that provides residence, custodial care, medical care, employment training, or other care or services for which the individual or agency receives a fee may not be appointed as guardian unless related to the respondent by blood, marriage, or adoption; and

(2) under section 245A.03, subdivision 2, paragraph (a), clause (1), a related individual as defined under section 245A.02, subdivision 13, is excluded from licensure. Services provided by a license holder to a person under the license holder's guardianship are not licensed services.

~~(c)~~ (d) Upon the transfer or death of a person, any funds or other property of the person must be surrendered to the person or the person's legal representative, or given to the executor or administrator of the estate in exchange for an itemized receipt.

Sec. 27. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 6, is amended to read:

Subd. 6. **Restricted procedures.** (a) The following procedures are allowed when the procedures are implemented in compliance with the standards governing their use as identified in clauses (1) to (3). Allowed but restricted procedures include:

(1) permitted actions and procedures subject to the requirements in subdivision 7;

(2) procedures identified in a positive support transition plan subject to the requirements in subdivision 8; or

(3) emergency use of manual restraint subject to the requirements in section 245D.061.

For purposes of this chapter, this section supersedes the requirements identified in Minnesota Rules, part 9525.2740.

(b) A restricted procedure identified in paragraph (a) must not:

(1) be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

(2) be implemented with an adult in a manner that constitutes abuse or neglect as defined in section 626.5572, subdivision 2 or 17;

(3) be implemented in a manner that violates a person's rights identified in section 245D.04;

(4) restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, necessary clothing, or any protection required by state licensing standards or federal regulations governing the program;

(5) deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;

(6) be used for the convenience of staff, as punishment, as a substitute for adequate staffing, or as a consequence if the person refuses to participate in the treatment or services provided by the program;

(7) use prone restraint. For purposes of this section, "prone restraint" means use of manual restraint that places a person in a face-down position. Prone restraint does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, if the person is restored to a standing, sitting, or side-lying position as quickly as possible;

(8) apply back or chest pressure while a person is in a prone position as identified in clause (7), supine position, or side-lying position; or

(9) be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

Sec. 28. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 7, is amended to read:

Subd. 7. **Permitted actions and procedures.** (a) Use of the instructional techniques and intervention procedures as identified in paragraphs (b) and (c) is permitted when used on an intermittent or continuous basis. When used on a continuous basis, it must be addressed in a person's coordinated service and support plan addendum as identified in sections 245D.07 and 245D.071. For purposes of this chapter, the requirements of this subdivision supersede the requirements identified in Minnesota Rules, part 9525.2720.

(b) Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used:

(1) to calm or comfort a person by holding that person with no resistance from that person;

(2) to protect a person known to be at risk ~~or~~ of injury due to frequent falls as a result of a medical condition;

(3) to facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; ~~or~~

(4) to ~~briefly~~ block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others~~.~~ with less than 60 seconds of physical contact by staff; or

(5) to redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

(c) Restraint may be used as an intervention procedure to:

(1) allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition;

(2) assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm.; or

~~Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in section 245D.061, subdivision 3; or~~

(3) position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.

Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in subdivision 6, paragraph (b).

(d) Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.

(e) Use of an auxiliary device to ensure a person does not unfasten a seat belt when being transported in a vehicle in accordance with seat belt use requirements in section 169.686 does not constitute the use of mechanical restraint.

Sec. 29. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 8, is amended to read:

Subd. 8. **Positive support transition plan.** (a) License holders must develop a positive support transition plan on the forms and in the manner prescribed by the commissioner for a person who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. The positive support transition plan forms and instructions will supersede the requirements in Minnesota Rules, parts 9525.2750; 9525.2760; and 9525.2780. The positive support transition plan must phase out any existing plans for the emergency or programmatic use of aversive or deprivation procedures prohibited under this chapter within the following timelines:

(1) for persons receiving services from the license holder before January 1, 2014, the plan must be developed and implemented by February 1, 2014, and phased out no later than December 31, 2014; and

(2) for persons admitted to the program on or after January 1, 2014, the plan must be developed and implemented within 30 calendar days of service initiation and phased out no later than 11 months from the date of plan implementation.

(b) The commissioner has limited authority to grant approval for the emergency use of procedures identified in subdivision 6 that had been part of an approved positive support transition plan when a person is at imminent risk of serious injury as defined in section 245.91, subdivision 6, due to self-injurious behavior and the following conditions are met:

(1) the person's expanded support team approves the emergency use of the procedures; and

(2) the interim review panel established in section 245.8251, subdivision 4, recommends commissioner approval of the emergency use of the procedures.

(c) Written requests for the emergency use of the procedures must be developed and submitted to the commissioner by the designated coordinator with input from the person's expanded support team in accordance with the requirements set by the interim review panel, in addition to the following:

(1) a copy of the person's current positive support transition plan and copies of each positive support transition plan review containing data on the progress of the plan from the previous year;

(2) documentation of a good faith effort to eliminate the use of the procedures that had been part of an approved positive support transition plan;

(3) justification for the continued use of the procedures that identifies the imminent risk of serious injury due to the person's self-injurious behavior if the procedures were eliminated;

(4) documentation of the clinicians consulted in creating and maintaining the positive support transition plan; and

(5) documentation of the expanded support team's approval and the recommendation from the interim panel required under paragraph (b).

(d) A copy of the written request, supporting documentation, and the commissioner's final determination on the request must be maintained in the person's service recipient record.

Sec. 30. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 3, is amended to read:

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

~~(b) Within 45 days of service initiation the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to assess and determine the following based on the person's coordinated service and support plan and the requirements in subdivision 4 and section 245D.07, subdivision 1a:~~

~~(1) the scope of the services to be provided to support the person's daily needs and activities;~~

~~(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;~~

~~(3) the person's preferences for how services and supports are provided;~~

~~(4) whether the current service setting is the most integrated setting available and appropriate for the person; and~~

~~(5) how services must be coordinated across other providers licensed under this chapter serving the same person to ensure continuity of care for the person.~~

~~(c) Within the scope of services, the license holder must, at a minimum, assess the following areas:~~

~~(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;~~

~~(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and~~

~~(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others. The assessments must produce information about the person that is descriptive of the person's overall strengths, functional skills and abilities, and behaviors or symptoms.~~

(b) Within the scope of services, the license holder must, at a minimum, complete assessments in the following areas before the 45-day planning meeting:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others.

Assessments must produce information about the person that describes the person's overall strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a written request from the person or the person's legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review.

(c) Within 45 days of service initiation, the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the coordinated service and support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; and

(5) how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

Sec. 31. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 4, is amended to read:

Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the 45-day planning meeting, the license holder must develop ~~and document~~ a service plan that documents the service outcomes and supports based on the assessments completed under subdivision 3 and the requirements in section 245D.07, subdivision 1a. The outcomes and supports must be included in the coordinated service and support plan addendum.

(b) The license holder must document the supports and methods to be implemented to support the ~~accomplishment of~~ person and accomplish outcomes related to acquiring, retaining, or improving skills and physical, mental, and emotional health and well-being. The documentation must include:

(1) the methods or actions that will be used to support the person and to accomplish the service outcomes, including information about:

(i) any changes or modifications to the physical and social environments necessary when the service supports are provided;

(ii) any equipment and materials required; and

(iii) techniques that are consistent with the person's communication mode and learning style;

(2) the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;

(3) the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated; and

(4) the names of the staff or position responsible for implementing the supports and methods.

(c) Within 20 working days of the 45-day meeting, the license holder must obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and coordinated service and support plan addendum.

Sec. 32. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 5, is amended to read:

Subd. 5. ~~**Progress reviews**~~ **Service plan review and evaluation.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the service plan and the methods used to support the person and accomplish outcomes identified in

subdivisions 3 and 4. The license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in ~~progress~~ service plan review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year. The purpose of the service plan review is to determine whether changes are needed to the service plan based on the assessment information, the license holder's evaluation of progress towards accomplishing outcomes, or other information provided by the support team or expanded support team.

(b) The license holder must summarize the person's status and progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 in a written report sent to the person or the person's legal representative and case manager five working days prior to the review meeting, unless the person, the person's legal representative, or the case manager requests to receive the report at the time of the meeting.

(c) Within ten working days of the progress review meeting, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

Sec. 33. Minnesota Statutes 2013 Supplement, section 245D.081, subdivision 2, is amended to read:

Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery and evaluation of services provided by the license holder must be coordinated by a designated staff person. The designated coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities assigned in the person's coordinated service and support plan and the coordinated service and support plan addendum;

(2) taking the action necessary to facilitate the accomplishment of the outcomes according to the requirements in section 245D.07;

(3) instruction and assistance to direct support staff implementing the coordinated service and support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency; and

(4) evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to the requirements in section 245D.07.

(b) The license holder must ensure that the designated coordinator is competent to perform the required duties identified in paragraph (a) through education ~~and~~, training ~~in human services and disability-related fields~~, and work experience ~~in providing direct care services and supports to persons with disabilities~~ relevant to the needs of the general population of persons served by the license holder and the individual persons for whom the designated coordinator is responsible. The designated coordinator must have the skills and ability necessary to develop effective plans and to design and use data systems to measure effectiveness of services and supports. The license holder must verify and document competence according to the requirements in section 245D.09, subdivision 3. The designated coordinator must minimally have:

(1) a baccalaureate degree in a field related to human services, and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(2) an associate degree in a field related to human services, and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(3) a diploma in a field related to human services from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older; or

(4) a minimum of 50 hours of education and training related to human services and disabilities; and

(5) four years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3).

Sec. 34. Minnesota Statutes 2013 Supplement, section 245D.09, subdivision 3, is amended to read:

Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education to meet the person's needs and additional requirements as written in the coordinated service and support plan or coordinated service and support plan addendum, or when otherwise required by the case manager or

the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and to the needs of the general population of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the coordinated service and support plan or coordinated service and support plan addendum;

(2) demonstrated competency in the orientation and training areas required under this chapter, and when applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements. Competency in these areas is determined by the license holder through knowledge testing ~~and~~ or observed skill assessment conducted by the trainer or instructor; and

(3) except for a license holder who is the sole direct support staff, periodic performance evaluations completed by the license holder of the direct support staff person's ability to perform the job functions based on direct observation.

(b) Staff under 18 years of age may not perform overnight duties or administer medication.

Sec. 35. Minnesota Statutes 2013 Supplement, section 245D.09, subdivision 4a, is amended to read:

Subd. 4a. **Orientation to individual service recipient needs.** (a) Before having unsupervised direct contact with a person served by the program, or for whom the staff person has not previously provided direct support, or any time the plans or procedures identified in paragraphs (b) to ~~(f)~~ (g) are revised, the staff person must review and receive instruction on the requirements in paragraphs (b) to ~~(f)~~ (g) as they relate to the staff person's job functions for that person.

(b) Training and competency evaluations must include the following:

(1) appropriate and safe techniques in personal hygiene and grooming, including hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of daily living (ADLs) as defined under section 256B.0659, subdivision 1;

(2) an understanding of what constitutes a healthy diet according to data from the Centers for Disease Control and Prevention and the skills necessary to prepare that diet;

(3) skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) as defined under section 256B.0659, subdivision 1; and

(4) demonstrated competence in providing first aid.

(c) The staff person must review and receive instruction on the person's coordinated service and support plan or coordinated service and support plan addendum as it relates to the responsibilities assigned to the license holder, and when applicable, the person's individual abuse prevention plan, to achieve and demonstrate an understanding of the person as a unique individual, and how to implement those plans.

(d) The staff person must review and receive instruction on medication setup, assistance, or administration procedures established for the person when ~~medication administration is~~ assigned to the license holder according to section 245D.05, subdivision 1, paragraph (b). Unlicensed staff may ~~administer medications~~ perform medication setup or medication administration only after successful completion of a medication setup or medication administration training, from a training curriculum developed by a registered nurse~~, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant, or physician~~ or appropriate licensed health professional. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure unlicensed staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health care condition that affects the service options available to the person because the condition requires:

(1) specialized or intensive medical or nursing supervision; and

(2) nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.

(e) The staff person must review and receive instruction on the safe and correct operation of medical equipment used by the person to sustain life, including but not limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided by a licensed health care professional or a manufacturer's representative and incorporate an observed skill assessment to ensure staff demonstrate the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer's instructions.

(f) The staff person must review and receive instruction on what constitutes use of restraints, time out, and seclusion, including chemical restraint, and staff responsibilities related to the prohibitions of their use according to the requirements in section 245D.06, subdivision 5, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior and why they are not safe, and the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061.

(g) The staff person must review and receive instruction on mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness.

~~(g)~~ (h) In the event of an emergency service initiation, the license holder must ensure the training required in this subdivision occurs within 72 hours of the direct support staff person first having unsupervised contact with the person receiving services. The license holder must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

~~(h)~~ (i) License holders who provide direct support services themselves must complete the orientation required in subdivision 4, clauses (3) to (7).

Sec. 36. Minnesota Statutes 2013 Supplement, section 245D.091, subdivision 2, is amended to read:

Subd. 2. **Behavior professional qualifications.** A behavior professional providing behavioral support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), ~~as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans,~~ must have competencies in the following areas ~~related to~~ as required under the brain injury and community alternatives for disabled individuals waiver plans or successor plans:

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

(6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

(10) co-occurring mental disorders or neurocognitive disorder;

(11) demonstrated expertise with populations being served; and

(12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college

or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11); or

(vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services.

Sec. 37. Minnesota Statutes 2013 Supplement, section 245D.091, subdivision 3, is amended to read:

Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst providing behavioral support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), ~~as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans,~~ must have competencies in the following areas as required under the brain injury and community alternatives for disabled individuals waiver plans or successor plans:

(1) have obtained a baccalaureate degree, master's degree, or PhD in a social services discipline; or

(2) meet the qualifications of a mental health practitioner as defined in section 245.462, subdivision 17.

(b) In addition, a behavior analyst must:

(1) have four years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder;

(2) have received ten hours of instruction in functional assessment and functional analysis;

(3) have received 20 hours of instruction in the understanding of the function of behavior;

(4) have received ten hours of instruction on design of positive practices behavior support strategies;

(5) have received 20 hours of instruction on the use of behavior reduction approved strategies used only in combination with behavior positive practices strategies;

(6) be determined by a behavior professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives behavioral support; and

(7) be under the direct supervision of a behavior professional.

Sec. 38. Minnesota Statutes 2013 Supplement, section 245D.091, subdivision 4, is amended to read:

Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist providing behavioral support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), ~~as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans,~~ must ~~meet the following qualifications~~ have competencies in the following areas as required under the brain injury and community alternatives for disabled individuals waiver plans or successor plans:

(1) have an associate's degree in a social services discipline; or

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

(b) In addition, a behavior specialist must:

(1) have received a minimum of four hours of training in functional assessment;

(2) have received 20 hours of instruction in the understanding of the function of behavior;

(3) have received ten hours of instruction on design of positive practices behavioral support strategies;

(4) be determined by a behavior professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior reduction approved intervention to the person who receives behavioral support; and

(5) be under the direct supervision of a behavior professional.

Sec. 39. Minnesota Statutes 2013 Supplement, section 245D.10, subdivision 3, is amended to read:

Subd. 3. **Service suspension and service termination.** (a) The license holder must establish policies and procedures for temporary service suspension and service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also provide support to the person.

(b) The policy must include the following requirements:

(1) the license holder must notify the person or the person's legal representative and case manager in writing of the intended termination or temporary service suspension, and the person's right to seek a temporary order staying the termination of service according to the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

(2) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective when a license holder is providing intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c), and 30 days prior to termination for all other services licensed under this chapter. This notice may be given in conjunction with a notice of temporary service suspension;

(3) notice of temporary service suspension must be given on the first day of the service suspension;

~~(3)~~ (4) the license holder must provide information requested by the person or case manager when services are temporarily suspended or upon notice of termination;

~~(4)~~ (5) prior to giving notice of service termination or temporary service suspension, the license holder must document actions taken to minimize or eliminate the need for service suspension or termination;

~~(5)~~ (6) during the temporary service suspension or service termination notice period, the license holder ~~will~~ must work with the ~~appropriate county agency~~ support team or expanded support team to develop reasonable alternatives to protect the person and others;

~~(6)~~ (7) the license holder must maintain information about the service suspension or termination, including the written termination notice, in the service recipient record; and

~~(7)~~ (8) the license holder must restrict temporary service suspension to situations in which the person's conduct poses an imminent risk of physical harm to self or others and less restrictive or positive support strategies would not achieve and maintain safety.

Sec. 40. Minnesota Statutes 2013 Supplement, section 245D.11, subdivision 2, is amended to read:

Subd. 2. **Health and safety.** The license holder must establish policies and procedures that promote health and safety by ensuring:

(1) use of universal precautions and sanitary practices in compliance with section 245D.06, subdivision 2, clause (5);

(2) if the license holder operates a residential program, health service coordination and care according to the requirements in section 245D.05, subdivision 1;

(3) safe medication assistance and administration according to the requirements in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in consultation with a registered nurse, nurse practitioner, physician's assistant, or medical doctor and require completion of medication administration training according to the requirements in section 245D.09, subdivision 4a, paragraph (d). Medication assistance and administration includes, but is not limited to:

(i) providing medication-related services for a person;

(ii) medication setup;

(iii) medication administration;

(iv) medication storage and security;

(v) medication documentation and charting;

(vi) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;

(vii) coordination of medication refills;

(viii) handling changes to prescriptions and implementation of those changes;

(ix) communicating with the pharmacy; and

(x) coordination and communication with prescriber;

(4) safe transportation, when the license holder is responsible for transportation of persons, with provisions for handling emergency situations according to the requirements in section 245D.06, subdivision 2, clauses (2) to (4);

(5) a plan for ensuring the safety of persons served by the program in emergencies as defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies to the license holder. A license holder with a community residential setting or a day service facility license must ensure the policy and procedures comply with the requirements in section 245D.22, subdivision 4;

(6) a plan for responding to all incidents as defined in section 245D.02, subdivision 11; and reporting all incidents required to be reported according to section 245D.06, subdivision 1. The plan must:

(i) provide the contact information of a source of emergency medical care and transportation; and

(ii) require staff to first call 911 when the staff believes a medical emergency may be life threatening, or to call the mental health crisis intervention team or similar mental health response team or service when such a team is available and appropriate when the person is experiencing a mental health crisis; and

(7) a procedure for the review of incidents and emergencies to identify trends or patterns, and corrective action if needed. The license holder must establish and maintain a record-keeping system for the incident and emergency reports. Each incident and emergency report file must contain a written summary of the incident. The license holder must conduct a review of incident reports for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. Each incident report must include:

(i) the name of the person or persons involved in the incident. It is not necessary to identify all persons affected by or involved in an emergency unless the emergency resulted in an incident;

(ii) the date, time, and location of the incident or emergency;

(iii) a description of the incident or emergency;

(iv) a description of the response to the incident or emergency and whether a person's coordinated service and support plan addendum or program policies and procedures were implemented as applicable;

(v) the name of the staff person or persons who responded to the incident or emergency; and

(vi) the determination of whether corrective action is necessary based on the results of the review.

Sec. 41. Minnesota Statutes 2012, section 252.451, subdivision 2, is amended to read:

Subd. 2. **Vendor participation and reimbursement.** Notwithstanding requirements in ~~chapter~~ chapters 245A and 245D, and sections 252.28, 252.40 to 252.46, and 256B.501, vendors of day training and habilitation services may enter into written agreements with qualified businesses to provide additional training and supervision needed by individuals to maintain their employment.

Sec. 42. Minnesota Statutes 2013 Supplement, section 256B.439, subdivision 1, is amended to read:

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement quality profiles for nursing facilities and, beginning not later than

July 1, 2014, for home and community-based services providers, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. For purposes of this section, home and community-based services providers are defined as providers of home and community-based services under sections 256B.0625, subdivisions 6a, 7, and 19a; 256B.0913~~,~~; 256B.0915~~,~~; 256B.092~~, and~~; 256B.49~~,~~; and 256B.85, and intermediate care facilities for persons with developmental disabilities providers under section 256B.5013. To the extent possible, quality profiles must be developed for providers of services to older adults and people with disabilities, regardless of payor source, for the purposes of providing information to consumers. The quality profiles must be developed using existing data sets maintained by the commissioners of health and human services to the extent possible. The profiles must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, the ombudsman offices, counties, tribes, health plans, and other entities and the long-term care database maintained under section 256.975, subdivision 7. The profiles must be designed to provide information on quality to:

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

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

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

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

EFFECTIVE DATE. This section is effective retroactively from February 1, 2014.

Sec. 43. Minnesota Statutes 2013 Supplement, section 256B.439, subdivision 7, is amended to read:

Subd. 7. **Calculation of home and community-based services quality add-on.** ~~Effective~~ On July 1, 2015, the commissioner shall determine the quality add-on rate change and adjust payment rates for ~~participating~~ all home and community-based services providers for services rendered on or after that date. The adjustment to a provider payment rate determined under this subdivision shall become part of the ongoing rate paid to that provider. The payment rate for the quality add-on shall be a variable amount based on each provider's quality score as determined in subdivisions 1 and 2a. All home and community-based services providers shall receive a minimum rate increase under this

subdivision. In addition to a minimum rate increase, a home and community-based services provider shall receive a quality add-on payment. The commissioner shall limit the types of home and community-based services providers that may receive the quality add-on ~~and~~ based on availability of quality measures and outcome data. The commissioner shall limit the amount of the minimum rate increase and quality add-on payments to ~~operate the quality add-on within funds appropriated for this purpose and based on the availability of the quality measures~~ the equivalent of a one percent rate increase for all home and community-based services providers.

Sec. 44. Minnesota Statutes 2013 Supplement, section 256B.4912, subdivision 1, is amended to read:

Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers providing services to seniors and individuals with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

(1) agreements with enrolled waiver service providers to ensure providers meet Minnesota health care program requirements;

(2) regular reviews of provider qualifications, and including requests of proof of documentation; and

(3) processes to gather the necessary information to determine provider qualifications.

(b) Beginning July 1, 2012, staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.

(c) Beginning January 1, 2014, service owners and managerial officials overseeing the management or policies of services that provide direct contact as specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to reenrollment or revalidation or, for new providers, prior to initial enrollment if they have not already done so as a part of service licensure requirements.

Sec. 45. Minnesota Statutes 2012, section 256B.5012, is amended by adding a subdivision to read:

Subd. 16. **ICF/DD rate increases effective July 1, 2014.** (a) For each facility reimbursed under this section, for the rate period beginning July 1, 2014, the commissioner shall increase operating payments equal to four percent of the operating payment rates in effect on July 1, 2014. For each facility, the commissioner shall apply the rate increase

based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate in effect on the preceding date.

(b) To receive the rate increase under paragraph (a), each facility reimbursed under this section must submit to the commissioner documentation that identifies a quality improvement project the facility will implement by June 30, 2015. Documentation must be provided in a format specified by the commissioner. Projects must:

(1) improve the quality of life of intermediate care facility residents in a meaningful way;

(2) improve the quality of services in a measurable way; or

(3) deliver good quality service more efficiently.

(c) For a facility that fails to submit the documentation described in paragraph (b) by a date or in a format specified by the commissioner, the commissioner shall reduce the facility's rate by one percent effective January 1, 2015.

(d) Facilities that receive a rate increase under this subdivision shall use 75 percent of the rate increase to increase compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the facility or exercises control over the facility; and

(2) persons paid by the facility under a management contract.

This requirement is subject to audit by the commissioner.

(e) Compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (f).

(f) A facility that receives a rate adjustment under paragraph (a) that is subject to paragraphs (d) and (e) shall prepare and produce for the commissioner, upon request, a plan that specifies the amount of money the provider expects to receive that is subject to the requirements of paragraphs (d) and (e), as well as how that money will be distributed to increase compensation for employees. The commissioner may recover funds from a facility that fails to comply with this requirement.

(g) Within six months after the effective date of the rate adjustment, the facility shall post the distribution plan required under paragraph (f) for a period of at least six weeks in an area of the facility's operation to which all eligible employees have access, and shall provide instructions for employees who believe they have not received the wage and other compensation-related increases specified in the distribution plan. These instructions must include a mailing address, e-mail address, and telephone number that an employee may use to contact the commissioner or the commissioner's representative. Facilities shall make assurances to the commissioner of compliance with this subdivision using forms prescribed by the commissioner.

(h) For public employees, the increase for wages and benefits for certain staff is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a provider for pay increases for public employees under this subdivision may be used only for increases implemented within one month of the effective date of the rate increase and must not be used for increases implemented prior to that date.

Sec. 46. Laws 2013, chapter 108, article 14, section 2, subdivision 6, is amended to read:

Subd. 6. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Support Services Grants

	Appropriations by Fund	
General	8,915,000	13,333,000
Federal TANF	94,611,000	94,611,000

Paid Work Experience. $2,168,000 each year in fiscal years 2015 and 2016 is from the general fund for paid work experience for long-term MFIP recipients. Paid work includes full and partial wage subsidies and other related services such as job development, marketing, preworksite training, job coaching, and postplacement services. These are onetime appropriations. Unexpended funds for fiscal year 2015 do not

cancel, but are available to the commissioner for this purpose in fiscal year 2016.

Work Study Funding for MFIP Participants. $250,000 each year in fiscal years 2015 and 2016 is from the general fund to pilot work study jobs for MFIP recipients in approved postsecondary education programs. This is a onetime appropriation. Unexpended funds for fiscal year 2015 do not cancel, but are available for this purpose in fiscal year 2016.

Local Strategies to Reduce Disparities. $2,000,000 each year in fiscal years 2015 and 2016 is from the general fund for local projects that focus on services for subgroups within the MFIP caseload who are experiencing poor employment outcomes. These are onetime appropriations. Unexpended funds for fiscal year 2015 do not cancel, but are available to the commissioner for this purpose in fiscal year 2016.

Home Visiting Collaborations for MFIP Teen Parents. $200,000 per year in fiscal years 2014 and 2015 is from the general fund and $200,000 in fiscal year 2016 is from the federal TANF fund for technical assistance and training to support local collaborations that provide home visiting services for MFIP teen parents. The general fund appropriation is onetime. The federal TANF fund appropriation is added to the base.

Performance Bonus Funds for Counties. The TANF fund base is increased by $1,500,000 each year in fiscal years 2016 and 2017. The commissioner must allocate

this amount each year to counties that exceed their expected range of performance on the annualized three-year self-support index as defined in Minnesota Statutes, section 256J.751, subdivision 2, clause (6). This is a permanent base adjustment. Notwithstanding any contrary provisions in this article, this provision expires June 30, 2016.

Base Adjustment. The general fund base is decreased by $200,000 in fiscal year 2016 and $4,618,000 in fiscal year 2017. The TANF fund base is increased by $1,700,000 in fiscal years 2016 and 2017.

(b) Basic Sliding Fee Child Care Assistance Grants	36,836,000	42,318,000

Base Adjustment. The general fund base is increased by $3,778,000 in fiscal year 2016 and by $3,849,000 in fiscal year 2017.

(c) Child Care Development Grants	1,612,000	1,737,000
(d) Child Support Enforcement Grants	50,000	50,000

Federal Child Support Demonstration Grants. Federal administrative reimbursement resulting from the federal child support grant expenditures authorized under United States Code, title 42, section 1315, is appropriated to the commissioner for this activity.

(e) Children's Services Grants

	Appropriations by Fund	
General	49,760,000	52,961,000
Federal TANF	140,000	140,000

Adoption Assistance and Relative Custody Assistance. $37,453,000 in fiscal year 2014 and $37,453,000 in fiscal year 2015 is for

the adoption assistance and relative custody assistance programs. The commissioner shall determine with the commissioner of Minnesota Management and Budget the appropriation for Northstar Care for Children effective January 1, 2015. The commissioner may transfer appropriations for adoption assistance, relative custody assistance, and Northstar Care for Children between fiscal years and among programs to adjust for transfers across the programs.

Title IV-E Adoption Assistance. Additional federal reimbursements to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance are appropriated for postadoption services, including a parent-to-parent support network.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2014 and 2015 for adoption incentive grants are appropriated for postadoption services, including a parent-to-parent support network.

Base Adjustment. The general fund base is increased by $5,913,000 in fiscal year 2016 and by $10,297,000 in fiscal year 2017.

(f) Child and Community Service Grants	53,301,000	53,301,000
(g) Child and Economic Support Grants	21,047,000	20,848,000

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2014 do not cancel but are available for this purpose in fiscal year 2015.

Transitional Housing. $250,000 each year is for the transitional housing programs under Minnesota Statutes, section 256E.33.

Emergency Services. $250,000 each year is for emergency services grants under Minnesota Statutes, section 256E.36.

Family Assets for Independence. $250,000 each year is for the Family Assets for Independence Minnesota program. This appropriation is available in either year of the biennium and may be transferred between fiscal years.

Food Shelf Programs. $375,000 in fiscal year 2014 and $375,000 in fiscal year 2015 are for food shelf programs under Minnesota Statutes, section 256E.34. If the appropriation for either year is insufficient, the appropriation for the other year is available for it. Notwithstanding Minnesota Statutes, section 256E.34, subdivision 4, no portion of this appropriation may be used by Hunger Solutions for its administrative expenses, including but not limited to rent and salaries.

Homeless Youth Act. $2,000,000 in fiscal year 2014 and $2,000,000 in fiscal year 2015 is for purposes of Minnesota Statutes, section 256K.45.

Safe Harbor Shelter and Housing. $500,000 in fiscal year 2014 and $500,000 in

fiscal year 2015 is for a safe harbor shelter and housing fund for housing and supportive services for youth who are sexually exploited.

(h) Health Care Grants

Appropriations by Fund		
General	190,000	190,000
Health Care Access	190,000	190,000

Emergency Medical Assistance Referral and Assistance Grants. (a) The commissioner of human services shall award grants to nonprofit programs that provide immigration legal services based on indigency to provide legal services for immigration assistance to individuals with emergency medical conditions or complex and chronic health conditions who are not currently eligible for medical assistance or other public health care programs, but who may meet eligibility requirements with immigration assistance.

(b) The grantees, in collaboration with hospitals and safety net providers, shall provide referral assistance to connect individuals identified in paragraph (a) with alternative resources and services to assist in meeting their health care needs. $100,000 is appropriated in fiscal year 2014 and $100,000 in fiscal year 2015. This is a onetime appropriation.

Base Adjustment. The general fund is decreased by $100,000 in fiscal year 2016 and $100,000 in fiscal year 2017.

	~~14,827,000~~	~~15,010,000~~
(i) Aging and Adult Services Grants	14,812,000	14,936,000

Base Adjustment. The general fund base is increased by ~~$1,150,000~~ $1,077,000 in fiscal year 2016 and ~~$1,151,000~~ $1,077,000 in fiscal year 2017.

Community Service Development Grants and Community Services Grants. Community service development grants and community services grants are reduced by $1,150,000 each year. This is a onetime reduction.

(j) Deaf and Hard-of-Hearing Grants	1,771,000	1,785,000
(k) Disabilities Grants	18,605,000	18,823,000

Advocating Change Together. $310,000 in fiscal year 2014 is for a grant to Advocating Change Together (ACT) to maintain and promote services for persons with intellectual and developmental disabilities throughout the state. This appropriation is onetime. Of this appropriation:

(1) $120,000 is for direct costs associated with the delivery and evaluation of peer-to-peer training programs administered throughout the state, focusing on education, employment, housing, transportation, and voting;

(2) $100,000 is for delivery of statewide conferences focusing on leadership and skill development within the disability community; and

(3) $90,000 is for administrative and general operating costs associated with managing or maintaining facilities, program delivery, staff, and technology.

Base Adjustment. The general fund base is increased by $535,000 in fiscal year 2016 and by $709,000 in fiscal year 2017.

(l) Adult Mental Health Grants

	Appropriations by Fund	
General	71,199,000	69,530,000
Health Care Access	750,000	750,000
Lottery Prize	1,733,000	1,733,000

Problem Gambling. $225,000 in fiscal year 2014 and $225,000 in fiscal year 2015 is appropriated from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling.

Funding Usage. Up to 75 percent of a fiscal year's appropriations for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is decreased by $4,427,000 in fiscal years 2016 and 2017.

Mental Health Pilot Project. $230,000 each year is for a grant to the Zumbro Valley Mental Health Center. The grant shall be used to implement a pilot project to test an integrated behavioral health care coordination model. The grant recipient must report measurable outcomes and savings

to the commissioner of human services by January 15, 2016. This is a onetime appropriation.

High-risk adults. $200,000 in fiscal year 2014 is for a grant to the nonprofit organization selected to administer the demonstration project for high-risk adults under Laws 2007, chapter 54, article 1, section 19, in order to complete the project. This is a onetime appropriation.

(m) Child Mental Health Grants	18,246,000	20,636,000

Text Message Suicide Prevention Program. $625,000 in fiscal year 2014 and $625,000 in fiscal year 2015 is for a grant to a nonprofit organization to establish and implement a statewide text message suicide prevention program. The program shall implement a suicide prevention counseling text line designed to use text messaging to connect with crisis counselors and to obtain emergency information and referrals to local resources in the local community. The program shall include training within schools and communities to encourage the use of the program.

Mental Health First Aid Training. $22,000 in fiscal year 2014 and $23,000 in fiscal year 2015 is to train teachers, social service personnel, law enforcement, and others who come into contact with children with mental illnesses, in children and adolescents mental health first aid training.

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that

portion of the fiscal year ending December 31.

(n) CD Treatment Support Grants 1,816,000 1,816,000

SBIRT Training. (1) $300,000 each year is for grants to train primary care clinicians to provide substance abuse brief intervention and referral to treatment (SBIRT). This is a onetime appropriation. The commissioner of human services shall apply to SAMHSA for an SBIRT professional training grant.

(2) If the commissioner of human services receives a grant under clause (1) funds appropriated under this clause, equal to the grant amount, up to the available appropriation, shall be transferred to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). MOFAS must use the funds for grants. Grant recipients must be selected from communities that are not currently served by federal Substance Abuse Prevention and Treatment Block Grant funds. Grant money must be used to reduce the rates of fetal alcohol syndrome and fetal alcohol effects, and the number of drug-exposed infants. Grant money may be used for prevention and intervention services and programs, including, but not limited to, community grants, professional eduction, public awareness, and diagnosis.

Fetal Alcohol Syndrome Grant. $180,000 each year from the general fund is for a grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) to support nonprofit Fetal Alcohol Spectrum Disorders (FASD) outreach prevention programs

in Olmsted County. This is a onetime appropriation.

Base Adjustment. The general fund base is decreased by $480,000 in fiscal year 2016 and $480,000 in fiscal year 2017.

Sec. 47. **PROVIDER RATE AND GRANT INCREASES EFFECTIVE JULY 1, 2014.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by four percent for the rate period beginning July 1, 2014, for services rendered on or after that date. County or tribal contracts for services specified in this section must be amended to pass through these rate increases within 60 days of the effective date.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waiver services for persons with developmental disabilities, including consumer-directed community supports, under Minnesota Statutes, section 256B.092;

(2) waiver services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(3) community alternative care waiver services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) brain injury waiver services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) home and community-based waiver services for the elderly under Minnesota Statutes, section 256B.0915;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) community first services and supports under Minnesota Statutes, section 256B.85;

(10) essential community supports under Minnesota Statutes, section 256B.0922;

(11) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.41 to 252.46, including the

additional cost to counties for rate adjustments to day training and habilitation services provided as a social service;

(12) alternative care services under Minnesota Statutes, section 256B.0913;

(13) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(14) consumer support grants under Minnesota Statutes, section 256.476;

(15) semi-independent living services under Minnesota Statutes, section 252.275;

(16) family support grants under Minnesota Statutes, section 252.32;

(17) housing access grants under Minnesota Statutes, section 256B.0658;

(18) self-advocacy grants under Laws 2009, chapter 101;

(19) technology grants under Laws 2009, chapter 79;

(20) aging grants under Minnesota Statutes, sections 256.975 to 256.977 and 256B.0917;

(21) deaf and hard-of-hearing grants, including community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2;

(22) deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233, 256C.25, and 256C.261;

(23) Disability Linkage Line grants under Minnesota Statutes, section 256.01, subdivision 24;

(24) transition initiative grants under Minnesota Statutes, section 256.478;

(25) employment support grants under Minnesota Statutes, section 256B.021, subdivision 6; and

(26) grants provided to people who are eligible for the Housing Opportunities for Persons with AIDS program under Minnesota Statutes, section 256B.492.

(c) A managed care plan receiving state payments for the services in paragraph (b) must include the increases in paragraph (a) in payments to providers. To implement the rate increase in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a four percent increase for the specified services for the period beginning July 1, 2014.

(d) Counties shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

(e) To implement this section, the commissioner shall increase service rates in the disability waiver payment system authorized in Minnesota Statutes, sections 256B.4913 and 256B.4914.

(f) To receive the rate increase described in this section, providers under paragraphs (a) and (b) must submit to the commissioner documentation that identifies a quality improvement project that the provider will implement by June 30, 2015. Documentation must be provided in a format specified by the commissioner. Projects must:

(1) improve the quality of life of home and community-based services recipients in a meaningful way;

(2) improve the quality of services in a measurable way; or

(3) deliver good quality service more efficiently.

Providers listed in paragraph (b), clauses (7), (9), (10), and (13) to (26), are not subject to this requirement.

(g) For a provider that fails to submit documentation described in paragraph (f) by a date or in a format specified by the commissioner, the commissioner shall reduce the provider's rate by one percent effective January 1, 2015.

(h) Providers that receive a rate increase under this subdivision shall use 75 percent of the rate increase to increase compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the facility or exercises control over the facility; and

(2) persons paid by the facility under a management contract.

This requirement is subject to audit by the commissioner.

(i) Compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (k).

(j) For public employees, the increase for wages and benefits for certain staff is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a provider for pay increases for public employees under this section may be used only for increases implemented within one month of the effective date of the rate increase and must not be used for increases implemented prior to that date.

(k) A provider that receives a rate adjustment under paragraph (b) that is subject to paragraphs (h) and (i) shall prepare and produce for the commissioner, upon request, a plan that specifies the amount of money the provider expects to receive that is subject to the requirements of paragraphs (h) and (i), as well as how that money will be distributed to increase compensation for employees. The commissioner may recover funds from a facility that fails to comply with this requirement.

(l) Within six months after the effective date of the rate adjustment, the provider shall post the distribution plan required under paragraph (k) for a period of at least six weeks in an area of the provider's operation to which all eligible employees have access, and shall provide instructions for employees who believe they have not received the wage and other compensation-related increases specified in the distribution plan. These instructions must include a mailing address, e-mail address, and telephone number that an employee may use to contact the commissioner or the commissioner's representative. Providers shall make assurances to the commissioner of compliance with this section using forms prescribed by the commissioner.

Sec. 48. **REVISOR'S INSTRUCTION.**

In each section of Minnesota Statutes or part of Minnesota Rules referred to in column A, the revisor of statutes shall delete the word or phrase in column B and insert the phrase in column C. The revisor shall also make related grammatical changes and changes in headnotes.

Column A	Column B	Column C
section 158.13	defective persons	persons with intellectual disabilities
section 158.14	defective persons	persons with intellectual disabilities
section 158.17	defective persons	persons with intellectual disabilities
section 158.18	persons not defective	persons without intellectual disabilities
	defective person	person with intellectual disabilities
	defective persons	persons with intellectual disabilities
section 158.19	defective	person with intellectual disabilities
section 256.94	defective	children with intellectual disabilities and
section 257.175	defective	children with intellectual disabilities and
part 2911.1350	retardation	developmental disability

Sec. 49. **REPEALER.**

(a) Minnesota Statutes 2013 Supplement, section 245D.061, subdivision 3, is repealed.

(b) Minnesota Statutes 2012, section 245.825, subdivisions 1 and 1b, are repealed upon the effective date of rules adopted according to Minnesota Statutes, section 245.8251. The commissioner of human services shall notify the revisor of statutes when this occurs.

(c) Minnesota Statutes 2013 Supplement, sections 245D.02, subdivisions 2b, 2c, 3b, 5a, 8a, 15a, 15b, 23b, 28, 29, and 34a; 245D.06, subdivisions 5, 6, 7, and 8; and 245D.061, subdivisions 1, 2, 4, 5, 6, 7, 8, and 9, are repealed upon the effective date of rules adopted according to Minnesota Statutes, section 245.8251. The commissioner of human services shall notify the revisor of statutes when this occurs.

(d) Minnesota Rules, parts 9525.2700; and 9525.2810, are repealed upon the effective date of rules adopted according to Minnesota Statutes, section 245.8251. The commissioner of human services shall notify the revisor of statutes when this occurs.

ARTICLE 6

MISCELLANEOUS

Section 1. Minnesota Statutes 2012, section 254B.12, is amended to read:

254B.12 RATE METHODOLOGY.

Subdivision 1. **CCDTF rate methodology established.** The commissioner shall establish a new rate methodology for the consolidated chemical dependency treatment fund. The new methodology must replace county-negotiated rates with a uniform statewide methodology that must include a graduated reimbursement scale based on the patients' level of acuity and complexity. At least biennially, the commissioner shall review the financial information provided by vendors to determine the need for rate adjustments.

Subd. 2. **Payment methodology for state-operated vendors.** (a) Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop a separate payment methodology for chemical dependency treatment services provided under the consolidated chemical dependency treatment fund by a state-operated vendor. This payment methodology is effective for services provided on or after October 1, 2015, or on or after the receipt of federal approval, whichever is later.

(b) Before implementing an approved payment methodology under paragraph (a), the commissioner must also receive any necessary legislative approval of required changes to state law or funding.

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

Subd. 2. **Monthly rates; exemptions.** ~~The maximum group residential housing rate does not apply~~ This subdivision applies to a residence that on August 1, 1984, was licensed by the commissioner of health only as a boarding care home, certified by the commissioner of health as an intermediate care facility, and licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500 to 9520.0690. Notwithstanding the provisions of subdivision 1c, the rate paid to a facility reimbursed under this subdivision shall be determined under section 256B.431, or under section 256B.434 if the facility is accepted by the commissioner for participation in the alternative payment demonstration project. The rate paid to this facility shall also include adjustments to the group residential housing rate according to subdivision 1, and any adjustments applicable to supplemental service rates statewide.

APPENDIX
Article locations in H3215-1

245.825 AVERSIVE AND DEPRIVATION PROCEDURES; LICENSED FACILITIES AND SERVICES.

Subdivision 1. **Rules governing aversive and deprivation procedures.** The commissioner of human services shall by October, 1983, promulgate rules governing the use of aversive and deprivation procedures in all licensed facilities and licensed services serving persons with developmental disabilities, as defined in section 252.27, subdivision 1a. No provision of these rules shall encourage or require the use of aversive and deprivation procedures. The rules shall prohibit: (1) the application of certain aversive and deprivation procedures in facilities except as authorized and monitored by the commissioner; (2) the use of aversive and deprivation procedures that restrict the consumers' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (3) the use of faradic shock without a court order. The rule shall further specify that consumers may not be denied ordinary access to legal counsel and next of kin. In addition, the rule may specify other prohibited practices and the specific conditions under which permitted practices are to be carried out. For any persons receiving faradic shock, a plan to reduce and eliminate the use of faradic shock shall be in effect upon implementation of the procedure.

Subd. 1b. **Review and approval.** Notwithstanding the provisions of Minnesota Rules, parts 9525.2700 to 9525.2810, the commissioner may designate the county case manager to authorize the use of controlled procedures as defined in Minnesota Rules, parts 9525.2710, subpart 9, and 9525.2740, subparts 1 and 2, after review and approval by the interdisciplinary team and the internal review committee as required in Minnesota Rules, part 9525.2750, subparts 1a and 2. Use of controlled procedures must be reported to the commissioner in accordance with the requirements of Minnesota Rules, part 9525.2750, subpart 2a.

245D.02 DEFINITIONS.

Subd. 2b. **Aversive procedure.** "Aversive procedure" means the application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior.

Subd. 2c. **Aversive stimulus.** "Aversive stimulus" means an object, event, or situation that is presented immediately following a behavior in an attempt to suppress the behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines.

Subd. 3b. **Chemical restraint.** "Chemical restraint" means the administration of a drug or medication to control the person's behavior or restrict the person's freedom of movement and is not a standard treatment or dosage for the person's medical or psychological condition.

Subd. 5a. **Deprivation procedure.** "Deprivation procedure" means the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Oftentimes the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.

Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual restraint" means using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency.

Subd. 15a. **Manual restraint.** "Manual restraint" means physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.

Subd. 15b. **Mechanical restraint.** Except for devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement, or the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition, "mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term applies to the use of mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury.

Subd. 23b. **Positive support transition plan.** "Positive support transition plan" means the plan required in section 245D.06, subdivision 5, paragraph (b), to be developed by the expanded support team to implement positive support strategies to:

(1) eliminate the use of prohibited procedures as identified in section 245D.06, subdivision 5, paragraph (a);

(2) avoid the emergency use of manual restraint as identified in section 245D.061; and

(3) prevent the person from physically harming self or others.

Subd. 28. **Restraint.** "Restraint" means manual restraint as defined in subdivision 15a or mechanical restraint as defined in subdivision 15b, or any other form of restraint that results in limiting of the free and normal movement of body or limbs.

Subd. 29. **Seclusion.** "Seclusion" means the placement of a person alone in a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room.

Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an ongoing activity to a room, either locked or unlocked, or otherwise separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if the person chooses. For the purpose of this chapter, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out" does not include a person voluntarily moving from an ongoing activity to an unlocked room or otherwise separating from a situation or social contact with others if the person chooses. For the purposes of this definition, "voluntarily" means without being forced, compelled, or coerced.

245D.06 PROTECTION STANDARDS.

Subd. 5. **Prohibited procedures.** The license holder is prohibited from using chemical restraints, mechanical restraints, manual restraints, time out, seclusion, or any other aversive or deprivation procedure, as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

Subd. 6. **Restricted procedures.** The following procedures are allowed when the procedures are implemented in compliance with the standards governing their use as identified in clauses (1) to (3). Allowed but restricted procedures include:

(1) permitted actions and procedures subject to the requirements in subdivision 7;

(2) procedures identified in a positive support transition plan subject to the requirements in subdivision 8; or

(3) emergency use of manual restraint subject to the requirements in section 245D.061.

For purposes of this chapter, this section supersedes the requirements identified in Minnesota Rules, part 9525.2740.

Subd. 7. **Permitted actions and procedures.** (a) Use of the instructional techniques and intervention procedures as identified in paragraphs (b) and (c) is permitted when used on an intermittent or continuous basis. When used on a continuous basis, it must be addressed in a person's coordinated service and support plan addendum as identified in sections 245D.07 and 245D.071. For purposes of this chapter, the requirements of this subdivision supersede the requirements identified in Minnesota Rules, part 9525.2720.

(b) Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used:

(1) to calm or comfort a person by holding that person with no resistance from that person;

(2) to protect a person known to be at risk or injury due to frequent falls as a result of a medical condition;

(3) to facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; or

(4) to briefly block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others.

(c) Restraint may be used as an intervention procedure to:

(1) allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition;

(2) assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm.

Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in section 245D.061, subdivision 3; or

(3) position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.

(d) Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.

Subd. 8. **Positive support transition plan.** License holders must develop a positive support transition plan on the forms and in the manner prescribed by the commissioner for a person who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. The positive support transition plan forms and instructions will supersede the requirements in Minnesota Rules, parts 9525.2750; 9525.2760; and 9525.2780. The positive support transition plan must phase out any existing plans for the emergency or programmatic use of aversive or deprivation procedures prohibited under this chapter within the following timelines:

(1) for persons receiving services from the license holder before January 1, 2014, the plan must be developed and implemented by February 1, 2014, and phased out no later than December 31, 2014; and

(2) for persons admitted to the program on or after January 1, 2014, the plan must be developed and implemented within 30 calendar days of service initiation and phased out no later than 11 months from the date of plan implementation.

245D.061 EMERGENCY USE OF MANUAL RESTRAINTS.

Subdivision 1. **Standards for emergency use of manual restraints.** The license holder must ensure that emergency use of manual restraints complies with the requirements of this chapter and the license holder's policy and procedures as required under subdivision 10. For the purposes of persons receiving services governed by this chapter, this section supersedes the requirements identified in Minnesota Rules, part 9525.2770.

Subd. 2. **Conditions for emergency use of manual restraint.** Emergency use of manual restraint must meet the following conditions:

(1) immediate intervention must be needed to protect the person or others from imminent risk of physical harm; and

(2) the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

Subd. 3. **Restrictions when implementing emergency use of manual restraint.** (a) Emergency use of manual restraint procedures must not:

(1) be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

(2) be implemented with an adult in a manner that constitutes abuse or neglect as defined in section 626.5572, subdivisions 2 and 17;

(3) be implemented in a manner that violates a person's rights and protections identified in section 245D.04;

(4) restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing, or to any protection required by state licensing standards and federal regulations governing the program;

(5) deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;

(6) be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by the program; or

(7) use prone restraint. For the purposes of this section, "prone restraint" means use of manual restraint that places a person in a face-down position. This does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible. Applying back or chest pressure while a person is in the prone or supine position or face-up is prohibited.

Subd. 4. **Monitoring emergency use of manual restraint.** The license holder shall monitor a person's health and safety during an emergency use of a manual restraint. Staff monitoring the procedure must not be the staff implementing the procedure when possible. The license holder shall complete a monitoring form, approved by the commissioner, for each incident involving the emergency use of a manual restraint.

Subd. 5. **Reporting emergency use of manual restraint incident.** (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

(1) the staff and persons receiving services who were involved in the incident leading up to the emergency use of manual restraint;

(2) a description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of manual restraint;

(3) a description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented that identifies when, how, and how long the alternative measures were attempted before manual restraint was implemented;

(4) a description of the mental, physical, and emotional condition of the person who was restrained, and other persons involved in the incident leading up to, during, and following the manual restraint;

(5) whether there was any injury to the person who was restrained or other persons involved in the incident, including staff, before or as a result of the use of manual restraint;

(6) whether there was a debriefing with the staff, and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident and the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the report should identify whether a debriefing is planned; and

(7) a copy of the report must be maintained in the person's service recipient record.

(b) Each single incident of emergency use of manual restraint must be reported separately. For the purposes of this subdivision, an incident of emergency use of manual restraint is a single incident when the following conditions have been met:

(1) after implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety;

(2) upon the attempt to release the restraint, the person's behavior immediately re-escalates; and

(3) staff must immediately reimplement the restraint in order to maintain safety.

Subd. 6. **Internal review of emergency use of manual restraint.** (a) Within five working days of the emergency use of manual restraint, the license holder must complete and document an internal review of each report of emergency use of manual restraint. The review must include an evaluation of whether:

(1) the person's service and support strategies developed according to sections 245D.07 and 245D.071 need to be revised;

(2) related policies and procedures were followed;

(3) the policies and procedures were adequate;

(4) there is a need for additional staff training;

(5) the reported event is similar to past events with the persons, staff, or the services involved; and

(6) there is a need for corrective action by the license holder to protect the health and safety of persons.

(b) Based on the results of the internal review, the license holder must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the license holder, if any. The corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

(c) The license holder must maintain a copy of the internal review and the corrective action plan, if any, in the person's service recipient record.

Subd. 7. **Expanded support team review.** (a) Within five working days after the completion of the internal review required in subdivision 6, the license holder must consult with the expanded support team following the emergency use of manual restraint to:

(1) discuss the incident reported in subdivision 5, to define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served; and

(2) determine whether the person's coordinated service and support plan addendum needs to be revised according to sections 245D.07 and 245D.071 to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.

(b) The license holder must maintain a written summary of the expanded support team's discussion and decisions required in paragraph (a) in the person's service recipient record.

Subd. 8. **External review and reporting.** Within five working days of the expanded support team review, the license holder must submit the following to the Department of Human Services, and the Office of the Ombudsman for Mental Health and Developmental Disabilities, as required under section 245.94, subdivision 2a:

(1) the report required under subdivision 5;

(2) the internal review and the corrective action plan required under subdivision 6; and

(3) the summary of the expanded support team review required under subdivision 7.

Subd. 9. **Emergency use of manual restraints policy and procedures.** The license holder must develop, document, and implement a policy and procedures that promote service recipient rights and protect health and safety during the emergency use of manual restraints. The policy and procedures must comply with the requirements of this section and must specify the following:

(1) a description of the positive support strategies and techniques staff must use to attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others;

(2) a description of the types of manual restraints the license holder allows staff to use on an emergency basis, if any. If the license holder will not allow the emergency use of manual restraint, the policy and procedure must identify the alternative measures the license holder will require staff to use when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety;

(3) instructions for safe and correct implementation of the allowed manual restraint procedures;

(4) the training that staff must complete and the timelines for completion, before they may implement an emergency use of manual restraint. In addition to the training on this policy and procedure and the orientation and annual training required in section 245D.09, subdivision 4, the training for emergency use of manual restraint must incorporate the following subjects:

(i) alternatives to manual restraint procedures, including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others;

(ii) de-escalation methods, positive support strategies, and how to avoid power struggles;

(iii) simulated experiences of administering and receiving manual restraint procedures allowed by the license holder on an emergency basis;

(iv) how to properly identify thresholds for implementing and ceasing restrictive procedures;

(v) how to recognize, monitor, and respond to the person's physical signs of distress, including positional asphyxia;

(vi) the physiological and psychological impact on the person and the staff when restrictive procedures are used;

(vii) the communicative intent of behaviors; and

(viii) relationship building;

(5) the procedures and forms to be used to monitor the emergency use of manual restraints, including what must be monitored and the frequency of monitoring per each incident of emergency use of manual restraint, and the person or position who is responsible for monitoring the use;

(6) the instructions, forms, and timelines required for completing and submitting an incident report by the person or persons who implemented the manual restraint; and

(7) the procedures and timelines for conducting the internal review and the expanded support team review, and the person or position responsible for completing the reviews and for ensuring that corrective action is taken or the person's coordinated service and support plan addendum is revised, when determined necessary.

256.969 PAYMENT RATES.

Subd. 8b. **Admissions for persons who apply during hospitalization.** For admissions for individuals under section 256D.03, subdivision 3, paragraph (a), clause (2), that occur before the date of eligibility, payment for the days that the patient is eligible shall be established according to the methods of subdivision 14.

Subd. 9a. **Disproportionate population adjustments until July 1, 1993.** For admissions occurring between January 1, 1993 and June 30, 1993, the adjustment under this subdivision shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of one standard deviation above the arithmetic mean. The adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding

regional treatment centers and facilities of the federal Indian Health Service, and the result must be multiplied by 1.1.

The provisions of this paragraph are effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9.

Subd. 9b. **Implementation of ratable reductions.** Notwithstanding the provisions in subdivision 9, any ratable reductions required under that subdivision or subdivision 9a for fiscal year 1993 shall be implemented as follows:

(1) no ratable reductions shall be applied to admissions occurring between October 1, 1992, and December 31, 1992; and

(2) sufficient ratable reductions shall be taken from hospitals receiving a payment under subdivision 9a for admissions occurring between January 1, 1993, and June 30, 1993, to ensure that all state payments under subdivisions 9 and 9a during federal fiscal year 1993 qualify for federal match.

Subd. 11. **Special rates.** The commissioner may establish special rate-setting methodologies, including a per day operating and property payment system, for hospice, ventilator dependent, and other services on a hospital and recipient specific basis taking into consideration such variables as federal designation, program size, and admission from a medical assistance waiver or home care program. The data and rate calculation method shall conform to the requirements of subdivision 13, except that rates shall not be standardized by the case mix index or adjusted by relative values and hospice rates shall not exceed the amount allowed under federal law. Rates and payments established under this subdivision must meet the requirements of section 256.9685, subdivisions 1 and 2. The cost and charges used to establish rates shall only reflect inpatient medical assistance covered services. Hospital and claims data that are used to establish rates under this subdivision shall not be used to establish payments or relative values under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 13. **Neonatal transfers.** For admissions occurring on or after July 1, 1989, neonatal diagnostic category transfers shall have operating and property payment rates established at receiving hospitals which have neonatal intensive care units on a per day payment system that is based on the cost finding methods and allowable costs of the Medicare program during the base year. Other neonatal diagnostic category transfers shall have rates established according to subdivision 14. The rate per day for the neonatal service setting within the hospital shall be determined by dividing base year neonatal allowable costs by neonatal patient days. The operating payment rate portion of the rate shall be adjusted by the hospital cost index and the disproportionate population adjustment. For admissions occurring after the transition period specified in section 256.9695, subdivision 3, the operating payment rate portion of the rate shall be standardized by the case mix index and adjusted by relative values. The cost and charges used to establish rates shall only reflect inpatient services covered by medical assistance. Hospital and claims data used to establish rates under this subdivision shall not be used to establish rates under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 20. **Increases in medical assistance inpatient payments; conditions.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if:

(1) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For purposes of this paragraph, medical assistance does not include general assistance medical care.

(b) Medical assistance inpatient payments shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if:

(1) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For purposes of this paragraph, medical assistance does not include general assistance medical care.

(c) Medical assistance inpatient payment rates shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur on or after October 1, 1992, if:

(1) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For this paragraph, medical assistance does not include general assistance medical care.

(d) Medical assistance inpatient payment rates shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur after September 30, 1992, if:

(1) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For purposes of this paragraph, medical assistance does not include general assistance medical care.

Subd. 21. **Mental health or chemical dependency admissions; rates.** Admissions under the general assistance medical care program occurring on or after July 1, 1990, and admissions under medical assistance, excluding general assistance medical care, occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services and covered by medical assistance shall not be billable to any other governmental entity. Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

Subd. 22. **Hospital payment adjustment.** For admissions occurring from January 1, 1993 until June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1. Any payment under this clause must be reduced by the amount of any payment received under subdivision 9a. For purposes of this subdivision, medical assistance does not include general assistance medical care.

This subdivision is effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9.

Subd. 25. **Long-term hospital rates.** For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For

subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

Subd. 26. **Greater Minnesota payment adjustment after June 30, 2001.** (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23.

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

(1) 370 cesarean section with complicating diagnosis;

(2) 371 cesarean section without complicating diagnosis;

(3) 372 vaginal delivery with complicating diagnosis;

(4) 373 vaginal delivery without complicating diagnosis;

(5) 386 extreme immaturity and respiratory distress syndrome, neonate;

(6) 388 full-term neonates with other problems;

(7) 390 prematurity without major problems;

(8) 391 normal newborn;

(9) 385 neonate, died or transferred to another acute care facility;

(10) 425 acute adjustment reaction and psychosocial dysfunction;

(11) 430 psychoses;

(12) 431 childhood mental disorders; and

(13) 164-167 appendectomy.

Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena;

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause; and

(4) in addition to any payments under clauses (1) to (3), for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 17.9 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to eight percent of the total of the operating and property payment rates, and for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 59.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to nine percent of the total of the operating and property payment rates. After making any ratable adjustments required under paragraph (b), the commissioner shall proportionately reduce payments under clauses (2) and (3) by an amount needed to make payments under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199, paragraphs (a) to (d). The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received

by the commissioner under section 256B.199, paragraphs (a) to (d), except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments. Effective for federal disproportionate share hospital funds earned on payments reported under section 256B.199, paragraphs (a) to (d), for services rendered on or after April 1, 2010, payments shall not be made under this subdivision or subdivision 28.

(c) The payments under paragraph (a) shall be paid quarterly based on each hospital's operating and property payments from the second previous quarter, beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, paragraphs (a) to (d), whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, paragraphs (a) to (d), adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199, paragraphs (a) to (d), when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision. The commissioner shall utilize a settlement process based on finalized data to maximize revenue under section 256B.199, paragraphs (a) to (d), and payments under this section.

(f) For purposes of this subdivision, medical assistance does not include general assistance medical care.

Subd. 28. **Temporary rate increase for qualifying hospitals.** For the period from April 1, 2009, to September 30, 2010, for each hospital with a medical assistance utilization rate equal to or greater than 25 percent during the base year, the commissioner shall provide an equal percentage rate increase for each medical assistance admission. The commissioner shall estimate the percentage rate increase using as the state share of the increase the amount available under section 256B.199, paragraph (d). The commissioner shall settle up payments to qualifying hospitals based on actual payments under that section and actual hospital admissions.

256.9695 APPEALS OF RATES; PROHIBITED PRACTICES FOR HOSPITALS; TRANSITION RATES.

Subd. 3. **Transition.** Except as provided in section 256.969, subdivision 8, the commissioner shall establish a transition period for the calculation of payment rates from July 1, 1989, to the implementation date of the upgrade to the Medicaid management information system or July 1, 1992, whichever is earlier.

During the transition period:

(a) Changes resulting from section 256.969, subdivisions 7, 9, 10, 11, and 13, shall not be implemented, except as provided in section 256.969, subdivisions 12 and 20.

(b) The beginning of the 1991 rate year shall be delayed and the rates notification requirement shall not be applicable.

(c) Operating payment rates shall be indexed from the hospital's most recent fiscal year ending prior to January 1, 1991, by prorating the hospital cost index methodology in effect on January 1, 1989. For payments made for admissions occurring on or after June 1, 1990, until the implementation date of the upgrade to the Medicaid management information system the hospital cost index excluding the technology factor shall not exceed five percent. This hospital cost index limitation shall not apply to hospitals that meet the requirements of section 256.969, subdivision 20, paragraphs (a) and (b).

(d) Property and pass-through payment rates shall be maintained at the most recent payment rate effective for June 1, 1990. However, all hospitals are subject to the hospital cost index limitation of subdivision 2c, for two complete fiscal years. Property and pass-through costs shall be retroactively settled through the transition period. The laws in effect on the day before July 1, 1989, apply to the retroactive settlement.

(e) If the upgrade to the Medicaid management information system has not been completed by July 1, 1992, the commissioner shall make adjustments for admissions occurring on or after that date as follows:

(1) provide a ten percent increase to hospitals that meet the requirements of section 256.969, subdivision 20, or, upon written request from the hospital to the commissioner, 50

percent of the rate change that the commissioner estimates will occur after the upgrade to the Medicaid management information system; and

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. Any adjustment that is greater than zero shall be ratably reduced by 20 percent. In addition, every adjustment shall be reduced for payments under clause (1), and differences in the hospital cost index. Hospitals shall revise claims so that services provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect until the amount due to or owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for admissions occurring from July 1, 1992 to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

Subd. 4. **Study.** The commissioner shall contract for an evaluation of the inpatient and outpatient hospital payment systems. The study shall include recommendations concerning:

(1) more effective methods of assigning operating and property payment rates to specific services or diagnoses;

(2) effective methods of cost control and containment;

(3) fiscal impacts of alternative payment systems;

(4) the relationships of the use of and payment for inpatient and outpatient hospital services;

(5) methods to relate reimbursement levels to the efficient provision of services; and

(6) methods to adjust reimbursement levels to reflect cost differences between geographic areas.

The commissioner shall report the findings to the legislature by January 15, 1991, along with recommendations for implementation.

256N.26 BENEFITS AND PAYMENTS.

Subd. 7. **Special at-risk monthly payment for at-risk children in guardianship assistance and adoption assistance.** A child eligible for guardianship assistance under section 256N.22 or adoption assistance under section 256N.23 who is determined to be an at-risk child shall receive a special at-risk monthly payment of $1 per month basic, unless and until the potential disability manifests itself and the agreement is renegotiated to include reimbursement. Such an at-risk child shall receive neither a supplemental difficulty of care monthly rate under subdivision 4 nor home and vehicle modifications under subdivision 10, but must be considered for medical assistance under subdivision 2.

9525.2700 PURPOSE AND APPLICABILITY.

Subpart 1. **Purpose.** Parts 9525.2700 to 9525.2810 implement Minnesota Statutes, section 245.825 by setting standards that govern the use of aversive and deprivation procedures with persons who have a developmental disability and who are served by a license holder licensed by the commissioner under Minnesota Statutes, chapter 245A and section 252.28, subdivision 2.

Parts 9525.2700 to 9525.2810 are not intended to encourage or require the use of aversive and deprivation procedures. Rather, parts 9525.2700 to 9525.2810 encourage the use of positive approaches as an alternative to aversive or deprivation procedures and require documentation that positive approaches have been tried and have been unsuccessful as a condition of implementing an aversive or deprivation procedure.

The standards and requirements set by parts 9525.2700 to 9525.2810:

A. exempt from the requirements of parts 9525.2700 to 9525.2810 any procedures that are positive in approach or are minimally intrusive;

B. prohibit the use of certain actions and procedures specified in part 9525.2730;

C. control the use of aversive and deprivation procedures permitted under parts 9525.2700 to 9525.2810 by requiring development of an individual service plan, development of an individual program plan, informed consent from the person or the person's legal representative, and review and approval by the expanded interdisciplinary team and internal review committee;

D. establish criteria and procedures for emergency use of controlled aversive and deprivation procedures; and

E. assign a monitoring and technical assistance role to the regional review committees mandated by Minnesota Statutes, section 245.825.

Subp. 2. **Applicability.** Parts 9525.2700 to 9525.2810 govern the use of aversive and deprivation procedures with persons who have a developmental disability when those persons are served by a license holder:

A. licensed under parts 9525.1500 to 9525.1690 to provide training and habilitation services to adults with a developmental disability;

B. licensed under parts 9525.0215 to 9525.0355 as a residential program for persons with a developmental disability. If a requirement of parts 9525.0215 to 9525.0355differs from a requirement in Code of Federal Regulations, title 42, sections 483.400 to 483.480, an intermediate care facility for persons with a developmental disability shall comply with the rule or regulation that sets the more stringent standard;

C. licensed under parts 9525.2000 to 9525.2140 to provide residential-based habilitation services;

D. licensed under parts 9503.0005 to 9503.0175 and 9545.0750 to 9545.0855 to provide services to children with a developmental disability;

E. licensed under parts 9555.9600 to 9555.9730 as an adult day care center;

F. licensed under parts 9555.5105 to 9555.6265 to provide foster care for adults or under part 9545.0010 to 9545.0260 to provide foster care for children; or

G. licensed for any other service or program requiring licensure by the commissioner as a residential or nonresidential program serving persons with a developmental disability, as specified in Minnesota Statutes, section 245A.02.

Subp. 3. **Exclusion.** Parts 9525.2700 to 9525.2810 do not apply to:

A. treatments defined in parts 9515.0200 to 9515.0700 governing the administration of specified therapies to committed patients residing at regional centers; or

B. residential care or program services licensed under parts 9520.0500 to 9520.0690 to serve persons with mental illness.

9525.2810 PENALTY FOR NONCOMPLIANCE.

If a license holder governed by parts 9525.2700 to 9525.2810 does not comply with parts 9525.2700 to 9525.2810, the commissioner has the authority to take enforcement action pursuant to Minnesota Statutes, chapter 245A and section 252.28, subdivision 2.