State of Minnesota

HOUSE OF REPRESENTATIVES

SPECIAL SESSION

H. F. No. 14

05/24/2019 Authored by Liebling, Moran, Halverson, Schultz and Pinto
The bill was read for the first time

A bill for an act

relating to health and human services; modifying provisions relating to children and families, operations, direct care and treatment, continuing care for older adults, disability services, chemical and mental health, health care, health coverage, prescription drugs, health-related licensing boards, Health Department, and additional miscellaneous provisions; modifying provisions governing child care providers, child care assistance program, and medical assistance; establishing Child Welfare Training Academy; modifying sections relating to data; establishing Family Child Care Task Force; modifying provisions governing nursing facility property payment rates, disability waiver rate-setting, and home and community-based services; modifying requirements for substance use disorder treatment; establishing Community Competency Restoration Task Force; modifying step therapy exceptions; requiring certain coverage for PANDAS and PANS; establishing cost-sharing limits for prescription insulin drugs; establishing prescription drug repository program; requiring licensure of wholesale distributors and third-party logistics providers; modifying sections relating to borings; modifying provisions relating to hemp, cannabinoid products, and medical cannabis; designating Maternal Mental Health Awareness Month; establishing grant programs; modifying fees; making technical changes; requiring studies and reports; adjusting the forecast; appropriating money; amending Minnesota Statutes 2018, sections 13.46, subdivisions 2, 3, 4; 13.461, subdivision 28; 13.69, subdivision 1; 13.851, by adding a subdivision; 15C.02; 16A.055, subdivision 1a; 16A.724, subdivision 2; 18K.03; 62A.30, by adding a subdivision; 62D.12, by adding a subdivision; 62D.124, subdivision 3, by adding a subdivision; 62E.23, subdivision 3; 62E.24, subdivision 2; 62J.23, subdivision 2; 62J.495, subdivisions 1, 3; 62K.07; 62K.075; 62K.10, subdivision 5; 62Q.01, by adding a subdivision; 62Q.184, subdivisions 1, 3; 62Q.47; 62U.04, subdivision 4; 103I.005, subdivisions 2, 8a, 17a; 103I.205, subdivisions 1, 4, 9; 103I.208, subdivision 1; 103I.235, subdivision 3; 103I.301, subdivision 6, by adding a subdivision; 103I.601, subdivision 4; 119B.011, subdivisions 19, 20, by adding a subdivision; 119B.02, subdivisions 6, 7; 119B.025, subdivision 1, by adding a subdivision; 119B.03, subdivision 9; 119B.09, subdivisions 1, 7; 119B.095, subdivision 2, by adding a subdivision; 119B.125, subdivision 6; 119B.13, subdivisions 6, 7; 119B.16, subdivisions 1, 1a, 1b, by adding subdivisions; 144.057, subdivision 3; 144.121, subdivision 1a, by adding a subdivision; 144.1506, subdivision 2; 144.225, subdivisions 2, 2a, 7; 144.3831, subdivision 1; 144.412; 144.413, subdivisions 1, 4; 144.414, subdivisions 2, 3; 144.416; 144.4165; 144.4167, subdivision 4; 144.417, subdivision 4; 144.552; 144.562, subdivision 2; 144.586, by adding a subdivision; 144.966, subdivision

2; 144.99, subdivision 1; 144A.071, subdivisions 1a, 2, 3, 4a, 4c, 4d, 5a; 144A.073, subdivision 3c, by adding a subdivision; 144A.43, subdivisions 11, 30, by adding a subdivision; 144A.472, subdivisions 5, 7; 144A.473; 144A.474, subdivision 2; 144A.475, subdivisions 1, 2, 5; 144A.476, subdivision 1; 144A.479, subdivision 7, by adding a subdivision; 144A.4791, subdivisions 1, 3, 6, 7, 8, 9; 144A.4792, subdivisions 1, 2, 5, 10; 144A.4793, subdivision 6; 144A.4796, subdivision 2; 144A.4797, subdivision 3; 144A.4798; 144A.4799, subdivisions 1, 3; 144A.484, subdivision 1; 145.908, subdivision 1; 145.928, subdivisions 1, 7; 145.986, subdivisions 1, 1a, 4, 5, 6; 147.037, subdivision 1; 147.0375, subdivision 1; 147D.27, by adding a subdivision; 147E.40, subdivision 1, as amended; 147F.17, subdivision 1, as amended; 148.59; 148.6445, subdivisions 1, 2, 2a, 3, 4, 5, 6, 10; 148.7815, subdivision 1, as amended; 148E.180; 150A.06, subdivision 3, by adding subdivisions; 150A.091, by adding subdivisions; 151.01, subdivisions 23, 31, 35; 151.06, by adding a subdivision; 151.065, subdivisions 1, 2, 3, 6; 151.071, subdivision 2; 151.15, subdivision 1, by adding subdivisions; 151.19, subdivisions 1, 3; 151.211, subdivision 2, by adding a subdivision; 151.252, subdivisions 1, 1a, 3; 151.253, by adding a subdivision; 151.32; 151.40, subdivisions 1, 2; 151.43; 151.46; 151.47, subdivision 1, by adding a subdivision; 152.01, subdivision 9; 152.126, subdivisions 6, 7, by adding a subdivision; 152.22, subdivisions 6, 11, 13, by adding subdivisions; 152.25, subdivisions 1, 1a, 1c, 4; 152.27, subdivisions 2, 3, 4, 5, 6; 152.28, subdivision 1; 152.29, subdivisions 1, 2, 3, 3a; 152.31; 152.32, subdivision 2; 152.33, subdivisions 1, 2; 152.34; 152.36, subdivision 2; 157.22; 214.25, subdivision 2; 237.50, subdivisions 4a, 6a, 10a, 11, by adding subdivisions; 237.51, subdivisions 1, 5a; 237.52, subdivision 5; 237.53; 245.095; 245.4889, subdivision 1; 245.735, subdivision 3; 245A.02, subdivisions 3, 5a, 8, 9, 12, 14, 18, by adding subdivisions; 245A.03, subdivisions 1, 3; 245A.04, subdivisions 1, 2, 4, 6, 7, 10, by adding subdivisions; 245A.05; 245A.07, subdivisions 1, 2, 2a, 3; 245A.14, subdivisions 4, 8, by adding subdivisions; 245A.145, subdivisions 1, 2; 245A.151; 245A.16, subdivision 1; 245A.18, subdivision 2; 245A.40; 245A.41; 245A.50, subdivision 1; 245A.51, subdivision 3, by adding subdivisions; 245A.66, subdivisions 2, 3; 245C.02, subdivision 6a, by adding subdivisions; 245C.03, subdivision 1; 245C.05, subdivisions 4, 5, 5a; 245C.08, subdivisions 1, 3; 245C.10, by adding a subdivision; 245C.13, subdivision 2, by adding a subdivision; 245C.22, subdivisions 4, 5; 245C.24, subdivisions 1, 2, by adding a subdivision; 245C.30, subdivisions 1, 2, 3; 245D.03, subdivision 1; 245D.071, subdivisions 1, 5; 245D.081, subdivision 3; 245D.09, subdivisions 5, 5a; 245D.091, subdivisions 2, 3, 4; 245E.02, by adding a subdivision; 245E.06, subdivision 3; 245F.05, subdivision 2; 245G.01, subdivisions 8, 21, by adding subdivisions; 245G.04; 245G.05; 245G.06, subdivisions 1, 2, 4; 245G.07; 245G.08, subdivision 3; 245G.10, subdivision 4; 245G.11, subdivisions 7, 8; 245G.12; 245G.13, subdivision 1; 245G.15, subdivisions 1, 2; 245G.18, subdivisions 3, 5; 245G.19, subdivision 4; 245G.22, subdivisions 1, 2, 3, 4, 6, 7, 15, 16, 17, 19; 245H.01, by adding subdivisions; 245H.03, by adding a subdivision; 245H.07; 245H.10, subdivision 1; 245H.11; 245H.13, subdivision 5, by adding subdivisions; 245H.14, subdivisions 1, 2, 3, 4, 5, 6; 245H.15, subdivision 1; 246.54, by adding a subdivision; 246B.10; 252.27, subdivision 2a; 252.275, subdivision 3; 252.32, subdivision 1a; 252.41, subdivisions 3, 4, 5, 6, 7, 9; 252.42; 252.43; 252.44; 252.45; 254A.03, subdivision 3; 254A.19, by adding a subdivision; 254B.02, subdivision 1; 254B.03, subdivisions 2, 4; 254B.04, subdivision 1, by adding a subdivision; 254B.05, subdivisions 1, 1a, 1b, 5; 254B.06, subdivisions 1, 2; 256.01, subdivision 14b; 256.043, as added; 256.046, subdivision 1, by adding a subdivision; 256.9365; 256.962, subdivision 5; 256.969, subdivisions 2b, 3a, 9, 17, 19; 256.98, subdivisions 1, 8; 256.983, by adding a subdivision; 256B.02, subdivision 7; 256B.04, subdivisions 14, 21, 22, by adding a subdivision; 256B.055, subdivision 2; 256B.056, subdivisions 1, 3, 5c, 7a; 256B.0625, subdivisions 3b, 13, 13e, 13f, 17, 24, 30, 43, 45a, 57, by adding subdivisions; 256B.064, subdivisions 1a, 1b, 2, by adding subdivisions; 256B.0651, subdivision 17; 256B.0658; 256B.0659, subdivisions 3a, 11, 12, 13, 19, 21, 24, 28, by adding a subdivision; 256B.0757, subdivisions 1, 2, 4, by adding

subdivisions; 256B.0911, subdivisions 1a, 3a, 3f, 5, by adding a subdivision; 256B.0915, subdivisions 3a, 6; 256B.092, subdivision 1b; 256B.0921; 256B.27, subdivision 3; 256B.434, subdivisions 1, 3; 256B.49, subdivisions 13, 14; 256B.4912, by adding subdivisions; 256B.4913, subdivision 4a; 256B.4914, subdivisions 2, 3, as amended, 4, 5, 6, 7, 8, 9, 10, 10a, 14, 15, by adding a subdivision; 256B.5014; 256B.69, subdivision 4, by adding a subdivision; 256B.766; 256B.79, subdivisions 2, 3, 4, 5, 6; 256B.85, subdivisions 3, 10, 11, 12, 16, by adding a subdivision; 256I.03, subdivision 8; 256I.04, subdivisions 1, 2b, 2f, by adding subdivisions; 256I.06, subdivision 8; 256J.24, subdivision 5; 256K.45, subdivision 2; 256L.11, subdivision 2; 256M.41, subdivision 3, by adding a subdivision; 256R.02, subdivisions 8, 19, 33, by adding subdivisions; 256R.21, by adding a subdivision; 256R.25; 256R.26; 256R.44; 256R.50, subdivision 6; 260C.007, subdivision 18, by adding a subdivision; 260C.178, subdivision 1; 260C.201, subdivisions 1, 2, 6; 260C.212, subdivision 2; 260C.452, subdivision 4; 260C.503, subdivision 1; 518A.32, subdivision 3; 518A.51; 641.15, subdivision 3a; Laws 2017, chapter 13, article 1, section 15, as amended; Laws 2017, First Special Session chapter 6, article 1, sections 44; 45; article 3, section 49; article 5, section 11; article 8, sections 71, as amended; 72, as amended; Laws 2019, chapter 60, article 3, section 1, subdivision 5; proposing coding for new law in Minnesota Statutes, chapters 10; 62A; 62K; 62Q; 119B; 144; 144A; 148; 151; 214; 245; 245A; 245D; 256B; 256K; 256R; 260C; repealing Minnesota Statutes 2018, sections 119B.125, subdivision 8; 119B.16, subdivision 2; 144.414, subdivision 5; 144A.45, subdivision 6; 144A.481; 151.42; 151.44; 151.49; 151.50; 151.51; 151.55; 214.17; 214.18; 214.19; 214.20; 214.21; 214.22; 214.23; 214.24; 245E.06, subdivisions 2, 4, 5; 245H.10, subdivision 2; 246.18, subdivisions 8, 9; 252.41, subdivision 8; 252.431; 252.451; 254B.03, subdivision 4a; 256B.0625, subdivisions 31c, 63; 256B.0659, subdivision 22; 256B.0705; 256B.431, subdivisions 3i, 15, 16; 256B.434, subdivisions 6, 10; 256B.4913, subdivisions 4a, 5, 6, 7; 256B.79, subdivision 7; 256I.05, subdivision 3; 256L.11, subdivision 2a; 256R.53, subdivision 2; Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10; Minnesota Rules, parts 2960.3030, subpart 3; 3400.0185, subpart 5; 6400.6970; 7200.6100; 7200.6105; 9502.0425, subparts 4, 16, 17; 9503.0155, subpart 8; 9549.0057; 9549.0060, subpart 14.

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

ARTICLE 1

CHILDREN AND FAMILIES

Section 1. Minnesota Statutes 2018, section 119B.011, is amended by adding a subdivision to read:

Subd. 13b. **Homeless.** "Homeless" means a self-declared housing status as defined in the McKinney-Vento Homeless Assistance Act and United States Code, title 42, section 11302, paragraph (a).

EFFECTIVE DATE. This section is effective September 21, 2020.

Sec. 2. Minnesota Statutes 2018, section 119B.011, subdivision 19, is amended to read:

Subd. 19. **Provider.** "Provider" means:

(1) an individual or child care center or facility~~, either licensed or unlicensed, providing legal child care services as defined~~ licensed to provide child care under ~~section 245A.03~~ chapter 245A when operating within the terms of the license; ~~or~~

(2) a license exempt center required to be certified under chapter 245H;

(3) an individual or child care center or facility ~~holding~~ that: (i) holds a valid child care license issued by another state or a tribe ~~and providing~~; (ii) provides child care services in the licensing state or in the area under the licensing tribe's jurisdiction; and (iii) is in compliance with federal health and safety requirements as certified by the licensing state or tribe, or as determined by receipt of child care development block grant funds in the licensing state; or

(4) a legal nonlicensed child care provider as defined under section 119B.011, subdivision 16, providing legal child care services. A ~~legally unlicensed family~~ legal nonlicensed child care provider must be at least 18 years of age, and not a member of the MFIP assistance unit or a member of the family receiving child care assistance to be authorized under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 119B.011, subdivision 20, is amended to read:

Subd. 20. **Transition year families.** "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, or families who have received DWP assistance under section 256J.95 for at least ~~three~~ one of the last six months before losing eligibility for MFIP or DWP. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year child care may be used to support employment, approved education or training programs, or job search that meets the requirements of section 119B.10. Transition year child care is not available to families who have been disqualified from MFIP or DWP due to fraud.

EFFECTIVE DATE. This section is effective March 23, 2020.

Sec. 4. Minnesota Statutes 2018, section 119B.02, subdivision 7, is amended to read:

Subd. 7. **Child care market rate survey.** ~~Biennially,~~ The commissioner shall conduct the next survey of prices charged by child care providers in Minnesota in state fiscal year

2021 and every three years thereafter to determine the 75th percentile for like-care arrangements in county price clusters.

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

Sec. 5. Minnesota Statutes 2018, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. **Applications.** (a) Except as provided in paragraph (c), clause (4), the county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) counted income;

(8) spousal support and child support payments made to persons outside the household;

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) The county must mail a notice of approval or denial of assistance to the applicant within 30 calendar days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension.

(c) For an applicant who declares that the applicant is homeless and who meets the definition of homeless in section 119B.011, subdivision 13b, the county must:

(1) if information is needed to determine eligibility, send a request for information to the applicant within five working days after receiving the application;

(2) if the applicant is eligible, send a notice of approval of assistance within five working days after receiving the application;

(3) if the applicant is ineligible, send a notice of denial of assistance within 30 days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension;

(4) not require verifications required by paragraph (a) before issuing the notice of approval or denial; and

(5) follow limits set by the commissioner for how frequently expedited application processing may be used for an applicant under this paragraph.

(d) An applicant who declares that the applicant is homeless must submit proof of eligibility within three months of the date the application was received. If proof of eligibility is not submitted within three months, eligibility ends. A 15-day adverse action notice is required to end eligibility.

EFFECTIVE DATE. This section is effective September 21, 2020.

Sec. 6. Minnesota Statutes 2018, section 119B.025, is amended by adding a subdivision to read:

Subd. 5. **Information to applicants; child care fraud.** At the time of initial application and at redetermination, the county must provide written notice to the applicant or participant listing the activities that constitute child care fraud and the consequences of committing child care fraud. An applicant or participant shall acknowledge receipt of the child care fraud notice in writing.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 119B.03, subdivision 9, is amended to read:

Subd. 9. **Portability pool.** (a) The commissioner shall establish a pool of up to five percent of the annual appropriation for the basic sliding fee program to provide continuous child care assistance for eligible families who move between Minnesota counties. At the end of each allocation period, any unspent funds in the portability pool must be used for assistance under the basic sliding fee program. If expenditures from the portability pool exceed the amount of money available, the reallocation pool must be reduced to cover these shortages.

(b) ~~To be eligible for portable basic sliding fee assistance,~~ A family that has moved from a county in which it was receiving basic sliding fee assistance to a county with a waiting list for the basic sliding fee program must:

(1) meet the income and eligibility guidelines for the basic sliding fee program; and

(2) notify ~~the new county of residence within 60 days of moving and submit information to the new county of residence to verify eligibility for the basic sliding fee program~~ the family's previous county of residence of the family's move to a new county of residence.

(c) The receiving county must:

(1) accept administrative responsibility for applicants for portable basic sliding fee assistance at the end of the two months of assistance under the Unitary Residency Act;

(2) continue portability pool basic sliding fee assistance ~~for the lesser of six months or~~ until the family is able to receive assistance under the county's regular basic sliding program; and

(3) notify the commissioner through the quarterly reporting process of any family that meets the criteria of the portable basic sliding fee assistance pool.

EFFECTIVE DATE. This section is effective December 2, 2019.

Sec. 8. Minnesota Statutes 2018, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) have household income less than or equal to 67 percent of the state median income, adjusted for family size, at application and redetermination, and meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J; or

(2) have household income less than or equal to 47 percent of the state median income, adjusted for family size, at application and less than or equal to 67 percent of the state median income, adjusted for family size, at redetermination.

(b) Child care services must be made available as in-kind services.

(c) All applicants for child care assistance and families currently receiving child care assistance must be assisted and required to cooperate in establishment of paternity and enforcement of child support obligations for all children in the family at application and redetermination as a condition of program eligibility. For purposes of this section, a family is considered to meet the requirement for cooperation when the family complies with the requirements of section 256.741.

(d) All applicants for child care assistance and families currently receiving child care assistance must pay the co-payment fee under section 119B.12, subdivision 2, as a condition

of eligibility. The co-payment fee may include additional recoupment fees due to a child care assistance program overpayment.

(e) If a family has one child with a child care authorization and the child reaches 13 years of age or the child has a disability and reaches 15 years of age, the family remains eligible until the redetermination.

EFFECTIVE DATE. This section is effective June 29, 2020.

Sec. 9. Minnesota Statutes 2018, section 119B.095, subdivision 2, is amended to read:

Subd. 2. **Maintain steady child care authorizations.** (a) Notwithstanding Minnesota Rules, chapter 3400, the amount of child care authorized under section 119B.10 for employment, education, or an MFIP or DWP employment plan shall continue at the same number of hours or more hours until redetermination, including:

(1) when the other parent moves in and is employed or has an education plan under section 119B.10, subdivision 3, or has an MFIP or DWP employment plan; or

(2) when the participant's work hours are reduced or a participant temporarily stops working or attending an approved education program. Temporary changes include, but are not limited to, a medical leave, seasonal employment fluctuations, or a school break between semesters.

(b) The county may increase the amount of child care authorized at any time if the participant verifies the need for increased hours for authorized activities.

(c) The county may reduce the amount of child care authorized if a parent requests a reduction or because of a change in:

(1) the child's school schedule;

(2) the custody schedule; or

(3) the provider's availability.

(d) The amount of child care authorized for a family subject to subdivision 1, paragraph (b), must change when the participant's activity schedule changes. Paragraph (a) does not apply to a family subject to subdivision 1, paragraph (b).

(e) When a child reaches 13 years of age or a child with a disability reaches 15 years of age, the amount of child care authorized shall continue at the same number of hours or more hours until redetermination.

EFFECTIVE DATE. This section is effective June 29, 2020.

Sec. 10. Minnesota Statutes 2018, section 119B.095, is amended by adding a subdivision to read:

Subd. 3. **Assistance for persons who are homeless.** An applicant who is homeless and eligible for child care assistance is exempt from the activity participation requirements under this chapter for three months. The applicant under this subdivision is eligible for 60 hours of child care assistance per service period for three months from the date the county receives the application. Additional hours may be authorized as needed based on the applicant's participation in employment, education, or MFIP or DWP employment plan. To continue receiving child care assistance after the initial three months, the applicant must verify that the applicant meets eligibility and activity requirements for child care assistance under this chapter.

EFFECTIVE DATE. This section is effective September 21, 2020.

Sec. 11. Minnesota Statutes 2018, section 119B.16, subdivision 1, is amended to read:

Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant or recipient adversely affected by an action of a county agency ~~action~~ or the commissioner, for an action taken directly against the applicant or recipient, may request and receive a fair hearing in accordance with this subdivision and section 256.045. An applicant or recipient does not have a right to a fair hearing if a county agency or the commissioner takes action against a provider.

(b) A county agency must offer an informal conference to an applicant or recipient who is entitled to a fair hearing under this section. A county agency must advise an applicant or recipient that a request for a conference is optional and does not delay or replace the right to a fair hearing.

(c) If a provider's authorization is suspended, denied, or revoked, a county agency or the commissioner must mail notice to each child care assistance program recipient receiving care from the provider.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 12. Minnesota Statutes 2018, section 119B.16, subdivision 1a, is amended to read:

Subd. 1a. **Fair hearing allowed for providers.** (a) This subdivision applies to providers caring for children receiving child care assistance.

~~(b) A provider to whom a county agency has assigned responsibility for an overpayment may request a fair hearing in accordance with section 256.045 for the limited purpose of~~

~~challenging the assignment of responsibility for the overpayment and the amount of the overpayment. The scope of the fair hearing does not include the issues of whether the provider wrongfully obtained public assistance in violation of section 256.98 or was properly disqualified under section 256.98, subdivision 8, paragraph (c), unless the fair hearing has been combined with an administrative disqualification hearing brought against the provider under section 256.046.~~

(b) A provider may request a fair hearing according to sections 256.045 and 256.046 only if a county agency or the commissioner:

(1) denies or revokes a provider's authorization, unless the action entitles the provider to an administrative review under section 119B.161;

(2) assigns responsibility for an overpayment to a provider under section 119B.11, subdivision 2a;

(3) establishes an overpayment for failure to comply with section 119B.125, subdivision 6;

(4) seeks monetary recovery or recoupment under section 245E.02, subdivision 4, paragraph (c), clause (2);

(5) initiates an administrative fraud disqualification hearing; or

(6) issues a payment and the provider disagrees with the amount of the payment.

(c) A provider may request a fair hearing by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must be received by the Appeals Division no later than 30 days after the date a county or the commissioner mails the notice.

(d) The provider's appeal request must contain the following:

(1) each disputed item, the reason for the dispute, and, if applicable, an estimate of the dollar amount involved for each disputed item;

(2) the computation the provider believes to be correct, if applicable;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 13. Minnesota Statutes 2018, section 119B.16, subdivision 1b, is amended to read:

Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision 1a, the family in whose case the overpayment was created must be made a party to the fair hearing. All other issues raised by the family must be resolved in the same proceeding. When a family requests a fair hearing and claims that the county should have assigned responsibility for an overpayment to a provider, the provider must be made a party to the fair hearing.~~ The human services judge assigned to a fair hearing may join a family or a provider as a party to the fair hearing whenever joinder of that party is necessary to fully and fairly resolve ~~overpayment~~ issues raised in the appeal.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 14. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision to read:

Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision 1a, paragraph (b), a county agency or the commissioner must mail written notice to the provider against whom the action is being taken. Unless otherwise specified under chapter 119B or 245E or Minnesota Rules, chapter 3400, a county agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date.

(b) The notice shall state (1) the factual basis for the department's determination, (2) the action the department intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known, and (4) the provider's right to appeal the department's proposed action.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 15. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision to read:

Subd. 3. **Fair hearing stayed.** (a) If a county agency or the commissioner denies or revokes a provider's authorization based on a licensing action under section 245A.07, and the provider appeals, the provider's fair hearing must be stayed until the commissioner issues an order as required under section 245A.08, subdivision 5.

(b) If the commissioner denies or revokes a provider's authorization based on decertification under section 245H.07, and the provider appeals, the provider's fair hearing must be stayed until the commissioner issues a final order as required under section 245H.07.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 16. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision to read:

Subd. 4. **Final department action.** Unless the commissioner receives a timely and proper request for an appeal, a county agency's or the commissioner's action shall be considered a final department action.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 17. **[119B.161] ADMINISTRATIVE REVIEW.**

Subdivision 1. **Applicability.** A provider has the right to an administrative review under this section if (1) a payment was suspended under chapter 245E, or (2) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1) or (2).

Subd. 2. **Notice.** (a) A county agency or the commissioner must mail written notice to a provider within five days of suspending payment or denying or revoking the provider's authorization under subdivision 1.

(b) The notice must:

(1) state the provision under which a county agency or the commissioner is denying, revoking, or suspending the provider's authorization or suspending payment to the provider;

(2) set forth the general allegations leading to the denial, revocation, or suspension of the provider's authorization. The notice need not disclose any specific information concerning an ongoing investigation;

(3) state that the denial, revocation, or suspension of the provider's authorization is for a temporary period and explain the circumstances under which the action expires; and

(4) inform the provider of the right to submit written evidence and argument for consideration by the commissioner.

(c) Notwithstanding Minnesota Rules, part 3400.0185, if a county agency or the commissioner suspends payment to a provider under chapter 245E or denies or revokes a provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1) or (2), a county agency or the commissioner must send notice of service authorization closure to each affected family. The notice sent to an affected family is effective on the date the notice is created.

Subd. 3. **Duration.** If a provider's payment is suspended under chapter 245E or a provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph

(d), clause (1) or (2), the provider's denial, revocation, temporary suspension, or payment suspension remains in effect until:

(1) the commissioner or a law enforcement authority determines that there is insufficient evidence warranting the action and a county agency or the commissioner does not pursue an additional administrative remedy under chapter 245E or section 256.98; or

(2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

Subd. 4. **Good cause exception.** The commissioner may find that good cause exists not to deny, revoke, or suspend a provider's authorization, or not to continue a denial, revocation, or suspension of a provider's authorization if any of the following are applicable:

(1) a law enforcement authority specifically requested that a provider's authorization not be denied, revoked, or suspended because that action may compromise an ongoing investigation;

(2) the commissioner determines that the denial, revocation, or suspension should be removed based on the provider's written submission; or

(3) the commissioner determines that the denial, revocation, or suspension is not in the best interests of the program.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 18. Minnesota Statutes 2018, section 245E.06, subdivision 3, is amended to read:

Subd. 3. **Appeal of department ~~sanction~~ action.** ~~(a) If the department does not pursue a criminal action against a provider, license holder, controlling individual, or recipient for financial misconduct, but the department imposes an administrative sanction under section 245E.02, subdivision 4, paragraph (c), any individual or entity against whom the sanction was imposed may appeal the department's administrative sanction under this section pursuant to section 119B.16 or 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:~~

~~(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item, if appropriate;~~

~~(2) the computation that is believed to be correct, if appropriate;~~

~~(3) the authority in the statute or rule relied upon for each disputed item; and~~

~~(4) the name, address, and phone number of the person at the provider's place of business with whom contact may be made regarding the appeal.~~

~~(b) Notwithstanding section 245E.03, subdivision 4, an appeal is considered timely only if postmarked or received by the department's Appeals Division within 30 days after receiving a notice of department sanction.~~

~~(c) Before the appeal hearing, the department may deny or terminate authorizations or payment to the entity or individual if the department determines that the action is necessary to protect the public welfare or the interests of the child care assistance program.~~ A provider's rights related to the department's action taken under this chapter against a provider are established in sections 119B.16 and 119B.161.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 19. Minnesota Statutes 2018, section 256.01, subdivision 14b, is amended to read:

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to ~~test~~ initiate tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. The commissioner may authorize projects to use alternative methods of (1) screening, investigating, and assessing reports of child maltreatment, and (2) administrative reconsideration, administrative appeal, and judicial appeal of maltreatment determinations, provided the alternative methods used by the projects comply with the provisions of sections 256.045 and 626.556 ~~dealing~~ that deal with the rights of individuals who are the subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner shall only authorize alternative methods that comply with the public policy under section 626.556, subdivision 1. The commissioner may seek any federal approvals necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 21 years old and who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

(3) have a substantial number of children for whom determinations of maltreatment have occurred;

(4)(i) have capacity to respond to reports of abuse and neglect under section 626.556; or (ii) have codified the tribe's screening, investigation, and assessment of reports of child maltreatment procedures, if authorized to use an alternative method by the commissioner under paragraph (a);

(5) provide a wide range of services to families in need of child welfare services; and

(6) have a tribal-state title IV-E agreement in effect.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

(1) assessment and prevention of child abuse and neglect;

(2) family preservation;

(3) facilitative, supportive, and reunification services;

(4) out-of-home placement for children removed from the home for child protective purposes; and

(5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under section 626.556 for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child

welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section 245.4874, subdivision 1, paragraph (a), clause (12), for children who are eligible for the initiative and living on the reservation and who meet one of the following criteria:

(1) the child must be receiving child protective services;

(2) the child must be in foster care; or

(3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings. Nothing in this section shall alter responsibilities of the county for providing services under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to the White Earth Band. The plan shall include a financing proposal, definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012.

Sec. 20. Minnesota Statutes 2018, section 256J.24, subdivision 5, is amended to read:

Subd. 5. **MFIP transitional standard.** (a) The MFIP transitional standard is based on the number of persons in the assistance unit eligible for both food and cash assistance. The amount of the transitional standard is published annually by the Department of Human Services.

(b) The amount of the MFIP cash assistance portion of the transitional standard is increased $100 per month per household. This increase shall be reflected in the MFIP cash assistance portion of the transitional standard published annually by the commissioner.

EFFECTIVE DATE. This section is effective February 1, 2020.

Sec. 21. Minnesota Statutes 2018, section 256M.41, subdivision 3, is amended to read:

Subd. 3. **Payments ~~based on performance~~.** ~~(a)~~ The commissioner shall make payments under this section to each county ~~board on a calendar year basis in an amount determined under paragraph (b)~~ on or before July 10 of each year.

~~(b) Calendar year allocations under subdivision 1 shall be paid to counties in the following manner:~~

~~(1) 80 percent of the allocation as determined in subdivision 1 must be paid to counties on or before July 10 of each year;~~

~~(2) ten percent of the allocation shall be withheld until the commissioner determines if the county has met the performance outcome threshold of 90 percent based on face-to-face contact with alleged child victims. In order to receive the performance allocation, the county child protection workers must have a timely face-to-face contact with at least 90 percent of all alleged child victims of screened-in maltreatment reports. The standard requires that each initial face-to-face contact occur consistent with timelines defined in section 626.556, subdivision 10, paragraph (i). The commissioner shall make threshold determinations in January of each year and payments to counties meeting the performance outcome threshold shall occur in February of each year. Any withheld funds from this appropriation for counties that do not meet this requirement shall be reallocated by the commissioner to those counties meeting the requirement; and~~

~~(3) ten percent of the allocation shall be withheld until the commissioner determines that the county has met the performance outcome threshold of 90 percent based on face-to-face visits by the case manager. In order to receive the performance allocation, the total number of visits made by caseworkers on a monthly basis to children in foster care and children receiving child protection services while residing in their home must be at least~~

~~90 percent of the total number of such visits that would occur if every child were visited once per month. The commissioner shall make such determinations in January of each year and payments to counties meeting the performance outcome threshold shall occur in February of each year. Any withheld funds from this appropriation for counties that do not meet this requirement shall be reallocated by the commissioner to those counties meeting the requirement. For 2015, the commissioner shall only apply the standard for monthly foster care visits.~~

~~(c) The commissioner shall work with stakeholders and the Human Services Performance Council under section 402A.16 to develop recommendations for specific outcome measures that counties should meet in order to receive funds withheld under paragraph (b), and include in those recommendations a determination as to whether the performance measures under paragraph (b) should be modified or phased out. The commissioner shall report the recommendations to the legislative committees having jurisdiction over child protection issues by January 1, 2018.~~

Sec. 22. Minnesota Statutes 2018, section 256M.41, is amended by adding a subdivision to read:

Subd. 4. **County performance on child protection measures.** The commissioner shall set child protection measures and standards. The commissioner shall require an underperforming county to demonstrate that the county designated sufficient funds and implemented a reasonable strategy to improve child protection performance, including the provision of a performance improvement plan and additional remedies identified by the commissioner. The commissioner may redirect up to 20 percent of a county's funds under this section toward the performance improvement plan. Sanctions under section 256M.20, subdivision 3, related to noncompliance with federal performance standards also apply.

Sec. 23. Minnesota Statutes 2018, section 260C.007, subdivision 18, is amended to read:

Subd. 18. **Foster care.** (a) "Foster care" means ~~24 hour~~ 24-hour substitute care for ~~children placed away from their parents or guardian and~~ a child for whom a responsible social services agency has placement and care responsibility~~. "Foster care" includes, but is not limited to, placement~~ and:

(1) who is placed away from the child's parent or guardian in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities not excluded in this subdivision, child care institutions, and preadoptive homes~~.~~; or

(2) who is colocated with the child's parent or guardian in a licensed residential family-based substance use disorder treatment program as defined in subdivision 22a; or

(3) who is returned to the care of the child's parent or guardian from whom the child was removed under a trial home visit pursuant to section 260C.201, subdivision 1, paragraph (a), clause (3).

(b) A child is in foster care under this definition regardless of whether the facility is licensed and payments are made for the cost of care. Nothing in this definition creates any authority to place a child in a home or facility that is required to be licensed which is not licensed. "Foster care" does not include placement in any of the following facilities: hospitals, inpatient chemical dependency treatment facilities where the child is the recipient of the treatment, facilities that are primarily for delinquent children, any corrections facility or program within a particular correction's facility not meeting requirements for title IV-E facilities as determined by the commissioner, facilities to which a child is committed under the provision of chapter 253B, forestry camps, or jails. Foster care is intended to provide for a child's safety or to access treatment. Foster care must not be used as a punishment or consequence for a child's behavior.

Sec. 24. Minnesota Statutes 2018, section 260C.007, is amended by adding a subdivision to read:

Subd. 22a. **Licensed residential family-based substance use disorder treatment program.** "Licensed residential family-based substance use disorder treatment program" means a residential treatment facility that provides the parent or guardian with parenting skills training, parent education, or individual and family counseling, under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma according to recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing. The residential program must be licensed by the Department of Human Services under chapter 245A and sections 245G.01 to 245G.16, 245G.19, and 245G.21 as a residential substance use disorder treatment program specializing in the treatment of clients with children.

Sec. 25. Minnesota Statutes 2018, section 260C.178, subdivision 1, is amended to read:

Subdivision 1. **Hearing and release requirements.** (a) If a child was taken into custody under section 260C.175, subdivision 1, clause (1) or (2), item (ii), the court shall hold a

hearing within 72 hours of the time the child was taken into custody, excluding Saturdays, Sundays, and holidays, to determine whether the child should continue in custody.

(b) Unless there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited to, a requirement that the child undergo a chemical use assessment as provided in section 260C.157, subdivision 1.

(c) If the court determines there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered if returned to the care of the parent or guardian who has custody and from whom the child was removed, the court shall order the child into foster care as defined in section 260C.007, subdivision 18, under the legal responsibility of the responsible social services agency or responsible probation or corrections agency for the purposes of protective care as that term is used in the juvenile court rules or into the home of a noncustodial parent and order the noncustodial parent to comply with any conditions the court determines to be appropriate to the safety and care of the child, including cooperating with paternity establishment proceedings in the case of a man who has not been adjudicated the child's father. The court shall not give the responsible social services legal custody and order a trial home visit at any time prior to adjudication and disposition under section 260C.201, subdivision 1, paragraph (a), clause (3), but may order the child returned to the care of the parent or guardian who has custody and from whom the child was removed and order the parent or guardian to comply with any conditions the court determines to be appropriate to meet the safety, health, and welfare of the child.

(d) In determining whether the child's health or welfare would be immediately endangered, the court shall consider whether the child would reside with a perpetrator of domestic child abuse.

(e) The court, before determining whether a child should be placed in or continue in foster care under the protective care of the responsible agency, shall also make a determination, consistent with section 260.012 as to whether reasonable efforts were made to prevent placement or whether reasonable efforts to prevent placement are not required. In the case of an Indian child, the court shall determine whether active efforts, according to section 260.762 and the Indian Child Welfare Act of 1978, United States Code, title 25, section 1912(d), were made to prevent placement. The court shall enter a finding that the

responsible social services agency has made reasonable efforts to prevent placement when the agency establishes either:

(1) that it has actually provided services or made efforts in an attempt to prevent the child's removal but that such services or efforts have not proven sufficient to permit the child to safely remain in the home; or

(2) that there are no services or other efforts that could be made at the time of the hearing that could safely permit the child to remain home or to return home. When reasonable efforts to prevent placement are required and there are services or other efforts that could be ordered which would permit the child to safely return home, the court shall order the child returned to the care of the parent or guardian and the services or efforts put in place to ensure the child's safety. When the court makes a prima facie determination that one of the circumstances under paragraph (g) exists, the court shall determine that reasonable efforts to prevent placement and to return the child to the care of the parent or guardian are not required.

If the court finds the social services agency's preventive or reunification efforts have not been reasonable but further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(f) The court may not order or continue the foster care placement of the child unless the court makes explicit, individualized findings that continued custody of the child by the parent or guardian would be contrary to the welfare of the child and that placement is in the best interest of the child.

(g) At the emergency removal hearing, or at any time during the course of the proceeding, and upon notice and request of the county attorney, the court shall determine whether a petition has been filed stating a prima facie case that:

(1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

(2) the parental rights of the parent to another child have been involuntarily terminated;

(3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the parents' custodial rights to another child have been involuntarily transferred to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (e), clause (1); section 260C.515, subdivision 4; or a similar law of another jurisdiction;

(5) the parent has committed sexual abuse as defined in section 626.556, subdivision 2, against the child or another child of the parent;

(6) the parent has committed an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b); or

(7) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable.

(h) When a petition to terminate parental rights is required under section 260C.301, subdivision 4, or 260C.503, subdivision 2, but the county attorney has determined not to proceed with a termination of parental rights petition, and has instead filed a petition to transfer permanent legal and physical custody to a relative under section 260C.507, the court shall schedule a permanency hearing within 30 days of the filing of the petition.

(i) If the county attorney has filed a petition under section 260C.307, the court shall schedule a trial under section 260C.163 within 90 days of the filing of the petition except when the county attorney determines that the criminal case shall proceed to trial first under section 260C.503, subdivision 2, paragraph (c).

(j) If the court determines the child should be ordered into foster care and the child's parent refuses to give information to the responsible social services agency regarding the child's father or relatives of the child, the court may order the parent to disclose the names, addresses, telephone numbers, and other identifying information to the responsible social services agency for the purpose of complying with sections 260C.151, 260C.212, 260C.215, and 260C.221.

(k) If a child ordered into foster care has siblings, whether full, half, or step, who are also ordered into foster care, the court shall inquire of the responsible social services agency of the efforts to place the children together as required by section 260C.212, subdivision 2, paragraph (d), if placement together is in each child's best interests, unless a child is in placement for treatment or a child is placed with a previously noncustodial parent who is not a parent to all siblings. If the children are not placed together at the time of the hearing, the court shall inquire at each subsequent hearing of the agency's reasonable efforts to place the siblings together, as required under section 260.012. If any sibling is not placed with another sibling or siblings, the agency must develop a plan to facilitate visitation or ongoing contact among the siblings as required under section 260C.212, subdivision 1, unless it is contrary to the safety or well-being of any of the siblings to do so.

(l) When the court has ordered the child into foster care or into the home of a noncustodial parent, the court may order a chemical dependency evaluation, mental health evaluation,

medical examination, and parenting assessment for the parent as necessary to support the development of a plan for reunification required under subdivision 7 and section 260C.212, subdivision 1, or the child protective services plan under section 626.556, subdivision 10, and Minnesota Rules, part 9560.0228.

Sec. 26. **[260C.190] FAMILY-FOCUSED RESIDENTIAL PLACEMENT.**

Subdivision 1. **Placement.** (a) An agency with legal responsibility for a child under section 260C.178, subdivision 1, paragraph (c), or legal custody of a child under section 260C.201, subdivision 1, paragraph (a), clause (3), may colocate a child with a parent who is receiving services in a licensed residential family-based substance use disorder treatment program for up to 12 months.

(b) During the child's placement under paragraph (a), the agency: (1) may visit the child as the agency deems necessary and appropriate; (2) shall continue to have access to information under section 260C.208; and (3) shall continue to provide appropriate services to both the parent and the child.

(c) The agency may terminate the child's placement under paragraph (a) to protect the child's health, safety, or welfare and may remove the child to foster care without a prior court order or authorization.

Subd. 2. **Case plans.** (a) Before a child may be colocated with a parent in a licensed residential family-based substance use disorder treatment program, a recommendation that the child's placement with a parent is in the child's best interests must be documented in the child's case plan. Each child must have a written case plan developed with the parent and the treatment program staff that describes the safety plan for the child and the treatment program's responsibilities if the parent leaves or is discharged without completing the program. The treatment program must be provided with a copy of the case plan that includes the recommendations and safety plan at the time the child is colocated with the parent.

(b) An out-of-home placement plan under section 260C.212, subdivision 1, must be completed no later than 30 days from when a child is colocated with a parent in a licensed residential family-based substance use disorder treatment program. The written plan developed with parent and treatment program staff in paragraph (a) may be updated and must be incorporated into the out-of-home placement plan. The treatment program must be provided with a copy of the child's out-of-home placement plan.

Subd. 3. **Required reviews and permanency proceedings.** (a) For a child colocated with a parent under subdivision 1, court reviews must occur according to section 260C.202.

(b) If a child has been in foster care for six months, a court review under section 260C.202 may be conducted in lieu of a permanency progress review hearing under section 260C.204 when the child is colocated with a parent consistent with section 260C.503, subdivision 3, paragraph (c), in a licensed residential family-based substance use disorder treatment program.

(c) If the child is colocated with a parent in a licensed residential family-based substance use disorder treatment program 12 months after the child was placed in foster care, the agency must file a report with the court regarding the parent's progress in the treatment program and the agency's reasonable efforts to finalize the child's safe and permanent return to the care and custody of the parent consistent with section 260C.503, subdivision 3, paragraph (c), in lieu of filing a petition required under section 260C.505.

(d) The court shall make findings regarding the reasonable efforts of the agency to finalize the child's return home as the permanency disposition order in the child's best interests. The court may continue the child's foster care placement colocated with a parent in a licensed residential family-based substance use disorder treatment program for up to 12 months. When a child has been in foster care placement for 12 months, but the duration of the colocation with a parent in a licensed residential family-based substance use disorder treatment program is less than 12 months, the court may continue the colocation with the total time spent in foster care not exceeding 15 out of the most recent 22 months. If the court finds that the agency fails to make reasonable efforts to finalize the child's return home as the permanency disposition order in the child's best interests, the court may order additional efforts to support the child remaining in the care of the parent.

(e) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program, the child's placement under this section is terminated and the agency may remove the child to foster care without a prior court order or authorization. Within three days of any termination of a child's placement, the agency shall notify the court and each party.

(f) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program and the child has been in foster care for less than six months, the court must hold a review hearing within ten days of receiving notice of a termination of a child's placement and must order an alternative disposition under section 260C.201.

(g) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program and the child is colocated

with a parent and the child has been in foster care for more than six months but less than 12 months, the court must conduct a permanency progress review hearing under section 260C.204 no later than 30 days after the day the parent leaves or is discharged.

(h) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program and the child is colocated with a parent and the child has been in foster care for more than 12 months, the court shall begin permanency proceedings under sections 260C.503 to 260C.521.

Sec. 27. Minnesota Statutes 2018, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. **Dispositions.** (a) If the court finds that the child is in need of protection or services or neglected and in foster care, it shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the responsible social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, the father must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in the father's home; and

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2; or

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the responsible social services agency. In making a foster care placement for a child whose custody has been transferred under this subdivision, the agency shall make an individualized determination of how the placement is in the child's best interests using the consideration for relatives ~~and~~, the best interest factors in section 260C.212, subdivision 2, paragraph (b), and may include a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190; or

(3) order a trial home visit without modifying the transfer of legal custody to the responsible social services agency under clause (2). Trial home visit means the child is returned to the care of the parent or guardian from whom the child was removed for a period not to exceed six months. During the period of the trial home visit, the responsible social services agency:

(i) shall continue to have legal custody of the child, which means the agency may see the child in the parent's home, at school, in a child care facility, or other setting as the agency deems necessary and appropriate;

(ii) shall continue to have the ability to access information under section 260C.208;

(iii) shall continue to provide appropriate services to both the parent and the child during the period of the trial home visit;

(iv) without previous court order or authorization, may terminate the trial home visit in order to protect the child's health, safety, or welfare and may remove the child to foster care;

(v) shall advise the court and parties within three days of the termination of the trial home visit when a visit is terminated by the responsible social services agency without a court order; and

(vi) shall prepare a report for the court when the trial home visit is terminated whether by the agency or court order which describes the child's circumstances during the trial home visit and recommends appropriate orders, if any, for the court to enter to provide for the child's safety and stability. In the event a trial home visit is terminated by the agency by removing the child to foster care without prior court order or authorization, the court shall conduct a hearing within ten days of receiving notice of the termination of the trial home visit by the agency and shall order disposition under this subdivision or ~~conduct a permanency hearing under subdivision 11 or 11a~~ commence permanency proceedings under sections 260C.503 to 260C.515. The time period for the hearing may be extended by the court for good cause shown and if it is in the best interests of the child as long as the total time the child spends in foster care without a permanency hearing does not exceed 12 months;

(4) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a physical or mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment

or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(5) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child or of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child, as defined in Laws 1997, chapter 239, article 10, section 2.

(e) When a parent has complied with a case plan ordered under subdivision 6 and the child is in the care of the parent, the court may order the responsible social services agency

to monitor the parent's continued ability to maintain the child safely in the home under such terms and conditions as the court determines appropriate under the circumstances.

Sec. 28. Minnesota Statutes 2018, section 260C.201, subdivision 2, is amended to read:

Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section shall contain written findings of fact to support the disposition and case plan ordered and shall also set forth in writing the following information:

(1) why the best interests and safety of the child are served by the disposition and case plan ordered;

(2) what alternative dispositions or services under the case plan were considered by the court and why such dispositions or services were not appropriate in the instant case;

(3) when legal custody of the child is transferred, the appropriateness of the particular placement made or to be made by the placing agency using the factors in section 260C.212, subdivision 2, paragraph (b), or the appropriateness of a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190;

(4) whether reasonable efforts to finalize the permanent plan for the child consistent with section 260.012 were made including reasonable efforts:

(i) to prevent the child's placement and to reunify the child with the parent or guardian from whom the child was removed at the earliest time consistent with the child's safety. The court's findings must include a brief description of what preventive and reunification efforts were made and why further efforts could not have prevented or eliminated the necessity of removal or that reasonable efforts were not required under section 260.012 or 260C.178, subdivision 1;

(ii) to identify and locate any noncustodial or nonresident parent of the child and to assess such parent's ability to provide day-to-day care of the child, and, where appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide day-to-day care of the child as required under section 260C.219, unless such services are not required under section 260.012 or 260C.178, subdivision 1;

(iii) to make the diligent search for relatives and provide the notices required under section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the agency has made diligent efforts to conduct a relative search and has appropriately engaged relatives who responded to the notice under section 260C.221 and other relatives, who came

to the attention of the agency after notice under section 260C.221 was sent, in placement and case planning decisions fulfills the requirement of this item;

(iv) to identify and make a foster care placement in the home of an unlicensed relative, according to the requirements of section 245A.035, a licensed relative, or other licensed foster care provider who will commit to being the permanent legal parent or custodian for the child in the event reunification cannot occur, but who will actively support the reunification plan for the child; and

(v) to place siblings together in the same home or to ensure visitation is occurring when siblings are separated in foster care placement and visitation is in the siblings' best interests under section 260C.212, subdivision 2, paragraph (d); and

(5) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the written findings shall also set forth:

(i) whether the child has mental health needs that must be addressed by the case plan;

(ii) what consideration was given to the diagnostic and functional assessments performed by the child's mental health professional and to health and mental health care professionals' treatment recommendations;

(iii) what consideration was given to the requests or preferences of the child's parent or guardian with regard to the child's interventions, services, or treatment; and

(iv) what consideration was given to the cultural appropriateness of the child's treatment or services.

(b) If the court finds that the social services agency's preventive or reunification efforts have not been reasonable but that further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(c) If the child has been identified by the responsible social services agency as the subject of concurrent permanency planning, the court shall review the reasonable efforts of the agency to develop a permanency plan for the child that includes a primary plan which is for reunification with the child's parent or guardian and a secondary plan which is for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner.

Sec. 29. Minnesota Statutes 2018, section 260C.201, subdivision 6, is amended to read:

Subd. 6. **Case plan.** (a) For each disposition ordered where the child is placed away from a parent or guardian, the court shall order the responsible social services agency to prepare a written out-of-home placement plan according to the requirements of section 260C.212, subdivision 1. When a foster child is colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190, the case plan must specify the recommendation for the colocation before the child is colocated with the parent.

(b) In cases where the child is not placed out of the home or is ordered into the home of a noncustodial parent, the responsible social services agency shall prepare a plan for delivery of social services to the child and custodial parent under section 626.556, subdivision 10, or any other case plan required to meet the needs of the child. The plan shall be designed to safely maintain the child in the home or to reunite the child with the custodial parent.

(c) The court may approve the case plan as presented or modify it after hearing from the parties. Once the plan is approved, the court shall order all parties to comply with it. A copy of the approved case plan shall be attached to the court's order and incorporated into it by reference.

(d) A party has a right to request a court review of the reasonableness of the case plan upon a showing of a substantial change of circumstances.

Sec. 30. Minnesota Statutes 2018, section 260C.212, subdivision 2, is amended to read:

Subd. 2. **Placement decisions based on best interests of the child.** (a) The policy of the state of Minnesota is to ensure that the child's best interests are met by requiring an individualized determination of the needs of the child and of how the selected placement will serve the needs of the child being placed. The authorized child-placing agency shall place a child, released by court order or by voluntary release by the parent or parents, in a family foster home selected by considering placement with relatives and important friends in the following order:

(1) with an individual who is related to the child by blood, marriage, or adoption; or

(2) with an individual who is an important friend with whom the child has resided or had significant contact.

For an Indian child, the agency shall follow the order of placement preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1915.

(b) Among the factors the agency shall consider in determining the needs of the child are the following:

(1) the child's current functioning and behaviors;

(2) the medical needs of the child;

(3) the educational needs of the child;

(4) the developmental needs of the child;

(5) the child's history and past experience;

(6) the child's religious and cultural needs;

(7) the child's connection with a community, school, and faith community;

(8) the child's interests and talents;

(9) the child's relationship to current caretakers, parents, siblings, and relatives;

(10) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences; and

(11) for an Indian child, the best interests of an Indian child as defined in section 260.755, subdivision 2a.

(c) Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child.

(d) Siblings should be placed together for foster care and adoption at the earliest possible time unless it is documented that a joint placement would be contrary to the safety or well-being of any of the siblings or unless it is not possible after reasonable efforts by the responsible social services agency. In cases where siblings cannot be placed together, the agency is required to provide frequent visitation or other ongoing interaction between siblings unless the agency documents that the interaction would be contrary to the safety or well-being of any of the siblings.

(e) Except for emergency placement as provided for in section 245A.035, the following requirements must be satisfied before the approval of a foster or adoptive placement in a related or unrelated home: (1) a completed background study under section 245C.08; and (2) a completed review of the written home study required under section 260C.215, subdivision 4, clause (5), or 260C.611, to assess the capacity of the prospective foster or adoptive parent to ensure the placement will meet the needs of the individual child.

(f) The agency must determine whether colocation with a parent who is receiving services in a licensed residential family-based substance use disorder treatment program is in the child's best interests according to paragraph (b) and include that determination in the child's case plan. The agency may consider additional factors not identified in paragraph (b). The agency's determination must be documented in the child's case plan before the child is colocated with a parent.

Sec. 31. **[260C.228] VOLUNTARY FOSTER CARE; CHILD IS COLOCATED WITH PARENT IN TREATMENT PROGRAM.**

Subdivision 1. **Generally.** When a parent requests assistance from an agency and both the parent and agency agree that a child's placement in foster care and colocation with a parent in a licensed residential family-based substance use treatment facility as defined by section 260C.007, subdivision 22a, is in the child's best interests, the agency must specify the recommendation for the placement in the child's case plan. After the child's case plan includes the recommendation, the agency and the parent may enter into a written voluntary placement agreement on a form approved by the commissioner.

Subd. 2. **Judicial review.** (a) A judicial review of a child's voluntary placement is required within 165 days of the date the voluntary agreement was signed. The agency responsible for the child's placement in foster care shall request the judicial review.

(b) The agency must forward a written report to the court at least five business days prior to the judicial review in paragraph (a). The report must contain:

(i) a statement regarding whether the colocation of the child with a parent in a licensed residential family-based substance use disorder treatment program meets the child's needs and continues to be in the child's best interests;

(ii) the child's name, dates of birth, race, gender, and current address;

(iii) the names, race, dates of birth, residences, and post office addresses of the child's parents or custodian;

(iv) a statement regarding the child's eligibility for membership or enrollment in an Indian tribe and the agency's compliance with applicable provisions of sections 260.751 to 260.835;

(v) the name and address of the licensed residential family-based substance use disorder treatment program where the child and parent or custodian are colocated;

(vi) a copy of the out-of-home placement plan under section 260C.212, subdivisions 1 and 3;

(vii) a written summary of the proceedings of any administrative review required under section 260C.203; and

(viii) any other information the agency, parent or custodian, child, or licensed residential family-based substance use disorder treatment program wants the court to consider.

(c) The agency must inform a child, if the child is 12 years of age or older; the child's parent; and the licensed residential family-based substance use disorder treatment program of the reporting and court review requirements of this section and of their rights to submit information to the court as follows:

(1) if the child, the child's parent, or the licensed residential family-based substance use disorder treatment program wants to send information to the court, the agency shall advise those persons of the reporting date and the date by which the agency must receive the information to submit to the court with the agency's report; and

(2) the agency must inform the child, the child's parent, and the licensed residential family-based substance use disorder treatment program that they have the right to be heard in person by the court. An in-person hearing must be held if requested by the child, parent or legal guardian, or licensed residential family-based substance use disorder treatment program.

(d) If, at the time required for the agency's report under this section, a child 12 years of age or older disagrees about the placement colocating the child with the parent in a licensed residential family-based substance use disorder treatment program or services provided under the out-of-home placement plan under section 260C.212, subdivision 1, the agency shall include information regarding the child's disagreement and to the extent possible the basis for the child's disagreement in the report.

(e) Regardless of whether an in-person hearing is requested within ten days of receiving the agency's report, the court has jurisdiction to and must determine:

(i) whether the voluntary foster care arrangement is in the child's best interests;

(ii) whether the parent and agency are appropriately planning for the child; and

(iii) if a child 12 years of age or older disagrees with the foster care placement colocating the child with the parent in a licensed residential family-based substance use disorder treatment program or services provided under the out-of-home placement plan, whether to appoint counsel and a guardian ad litem for the child according to section 260C.163.

(f) Unless requested by the parent, representative of the licensed residential family-based substance use disorder treatment program, or child, an in-person hearing is not required for the court to make findings and issue an order.

(g) If the court finds the voluntary foster care arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child, the court shall issue an order containing explicit individualized findings to support the court's determination. The individual findings shall be based on the agency's written report and other materials submitted to the court. The court may make this determination notwithstanding the child's disagreement, if any, reported to the court under paragraph (d).

(h) The court shall send a copy of the order to the county attorney, the agency, the parent, a child 12 years of age or older, and the licensed residential family-based substance use disorder treatment program.

(i) If the court finds continuing the voluntary foster care arrangement is not in the child's best interests or that the agency or the parent is not appropriately planning for the child, the court shall notify the agency, the parent, the licensed residential family-based substance use disorder treatment program, a child 12 years of age or older, and the county attorney of the court's determination and the basis for the court's determination. The court shall set the matter for hearing and appoint a guardian ad litem for the child under section 260C.163, subdivision 5.

Subd. 3. **Termination.** The voluntary placement agreement terminates at the parent's discharge from the licensed residential family-based substance use disorder treatment program, or upon receipt of a written and dated request from the parent, unless the request specifies a later date. If the child's voluntary foster care placement meets the calculated time to require a permanency proceeding under section 260C.503, subdivision 3, paragraph (a), and the child is not returned home, the agency must file a petition according to section 260C.141 or 260C.505.

Sec. 32. Minnesota Statutes 2018, section 260C.452, subdivision 4, is amended to read:

Subd. 4. **Administrative or court review of placements.** (a) When the child is 14 years of age or older, the court, in consultation with the child, shall review the independent living plan according to section 260C.203, paragraph (d).

(b) The responsible social services agency shall file a copy of the notification required in subdivision 3 with the court. If the responsible social services agency does not file the

notice by the time the child is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

(c) The court shall ensure that the responsible social services agency assists the child in obtaining the following documents before the child leaves foster care: a Social Security card; an official or certified copy of the child's birth certificate; a state identification card or driver's license, tribal enrollment identification card, green card, or school visa; health insurance information; the child's school, medical, and dental records; a contact list of the child's medical, dental, and mental health providers; and contact information for the child's siblings, if the siblings are in foster care.

(d) For a child who will be discharged from foster care at 18 years of age or older, the responsible social services agency must develop a personalized transition plan as directed by the child during the 90-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the child elects and include specific options, including but not limited to:

(1) affordable housing with necessary supports that does not include a homeless shelter;

(2) health insurance, including eligibility for medical assistance as defined in section 256B.055, subdivision 17;

(3) education, including application to the Education and Training Voucher Program;

(4) local opportunities for mentors and continuing support services, including the Healthy Transitions and Homeless Prevention program, if available;

(5) workforce supports and employment services;

(6) a copy of the child's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report, at no cost to the child;

(7) information on executing a health care directive under chapter 145C and on the importance of designating another individual to make health care decisions on behalf of the child if the child becomes unable to participate in decisions; ~~and~~

(8) appropriate contact information through 21 years of age if the child needs information or help dealing with a crisis situation~~.~~; and

(9) official documentation that the youth was previously in foster care.

Sec. 33. Minnesota Statutes 2018, section 260C.503, subdivision 1, is amended to read:

Subdivision 1. **Required permanency proceedings.** (a) Except for children in foster care pursuant to chapter 260D, where the child is in foster care or in the care of a noncustodial or nonresident parent, the court shall commence proceedings to determine the permanent status of a child by holding the admit-deny hearing required under section 260C.507 not later than 12 months after the child is placed in foster care or in the care of a noncustodial or nonresident parent. Permanency proceedings for children in foster care pursuant to chapter 260D shall be according to section 260D.07.

(b) Permanency proceedings for a foster child who is colocated with a parent in a licensed residential family-based substance use disorder treatment program shall be conducted according to section 260C.190.

Sec. 34. Minnesota Statutes 2018, section 518A.32, subdivision 3, is amended to read:

Subd. 3. **Parent not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis.** A parent is not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis upon a showing by the parent that:

(1) the unemployment, underemployment, or employment on a less than full-time basis is temporary and will ultimately lead to an increase in income;

(2) the unemployment, underemployment, or employment on a less than full-time basis represents a bona fide career change that outweighs the adverse effect of that parent's diminished income on the child; or

(3) the unemployment, underemployment, or employment on a less than full-time basis is because a parent is physically or mentally incapacitated or due to incarceration~~, except where the reason for incarceration is the parent's nonpayment of support~~.

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

Sec. 35. Minnesota Statutes 2018, section 518A.51, is amended to read:

518A.51 FEES FOR IV-D SERVICES.

(a) When a recipient of IV-D services is no longer receiving assistance under the state's title IV-A, IV-E foster care, or medical assistance programs, the public authority responsible for child support enforcement must notify the recipient, within five working days of the notification of ineligibility, that IV-D services will be continued unless the public authority

is notified to the contrary by the recipient. The notice must include the implications of continuing to receive IV-D services, including the available services and fees, cost recovery fees, and distribution policies relating to fees.

(b) In the case of an individual who has never received assistance under a state program funded under title IV-A of the Social Security Act and for whom the public authority has collected at least ~~$500~~ $550 of support, the public authority must impose an annual federal collections fee of ~~$25~~ $35 for each case in which services are furnished. This fee must be retained by the public authority from support collected on behalf of the individual, but not from the first ~~$500~~ $550 collected.

(c) When the public authority provides full IV-D services to an obligee who has applied for those services, upon written notice to the obligee, the public authority must charge a cost recovery fee of two percent of the amount collected. This fee must be deducted from the amount of the child support and maintenance collected and not assigned under section 256.741 before disbursement to the obligee. This fee does not apply to an obligee who:

(1) is currently receiving assistance under the state's title IV-A, IV-E foster care, or medical assistance programs; or

(2) has received assistance under the state's title IV-A or IV-E foster care programs, until the person has not received this assistance for 24 consecutive months.

(d) When the public authority provides full IV-D services to an obligor who has applied for such services, upon written notice to the obligor, the public authority must charge a cost recovery fee of two percent of the monthly court-ordered child support and maintenance obligation. The fee may be collected through income withholding, as well as by any other enforcement remedy available to the public authority responsible for child support enforcement.

(e) Fees assessed by state and federal tax agencies for collection of overdue support owed to or on behalf of a person not receiving public assistance must be imposed on the person for whom these services are provided. The public authority upon written notice to the obligee shall assess a fee of $25 to the person not receiving public assistance for each successful federal tax interception. The fee must be withheld prior to the release of the funds received from each interception and deposited in the general fund.

(f) Federal collections fees collected under paragraph (b) and cost recovery fees collected under paragraphs (c) and (d) retained by the commissioner of human services shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the special revenue fund account established

under paragraph (h). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

(g) The limitations of this section on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under title IV-A and title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

(h) The commissioner of human services is authorized to establish a special revenue fund account to receive the federal collections fees collected under paragraph (b) and cost recovery fees collected under paragraphs (c) and (d).

(i) The nonfederal share of the cost recovery fee revenue must be retained by the commissioner and distributed as follows:

(1) one-half of the revenue must be transferred to the child support system special revenue account to support the state's administration of the child support enforcement program and its federally mandated automated system;

(2) an additional portion of the revenue must be transferred to the child support system special revenue account for expenditures necessary to administer the fees; and

(3) the remaining portion of the revenue must be distributed to the counties to aid the counties in funding their child support enforcement programs.

(j) The nonfederal share of the federal collections fees must be distributed to the counties to aid them in funding their child support enforcement programs.

(k) The commissioner of human services shall distribute quarterly any of the funds dedicated to the counties under paragraphs (i) and (j) using the methodology specified in section 256.979, subdivision 11. The funds received by the counties must be reinvested in the child support enforcement program and the counties must not reduce the funding of their child support programs by the amount of the funding distributed.

EFFECTIVE DATE. This section is effective October 1, 2019.

Sec. 36. **INSTRUCTION TO COMMISSIONER.**

All individuals in connection with a licensed children's residential facility required to complete a background study under Minnesota Statutes, chapter 245C, must complete a new background study consistent with the obligations and requirements of this article. The commissioner of human services shall establish a schedule for (1) individuals in connection with a licensed children's residential facility that serves children eligible to receive federal

Title IV-E funding to complete the new background study by March 1, 2020, and (2) individuals in connection with a licensed children's residential facility that serves children not eligible to receive federal Title IV-E funding to complete the new background study by March 1, 2021.

Sec. 37. **CHILD WELFARE TRAINING ACADEMY.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services shall modify the Child Welfare Training System developed pursuant to Minnesota Statutes, section 626.5591, subdivision 2, according to this section. The new training framework shall be known as the Child Welfare Training Academy.

Subd. 2. **Administration.** (a) The Child Welfare Training Academy must be administered through five regional hubs in northwest, northeast, southwest, southeast, and central Minnesota. Each hub must deliver training targeted to the needs of the hub's particular region, taking into account varying demographics, resources, and practice outcomes.

(b) The Child Welfare Training Academy must use training methods best suited to the training content. National best practices in adult learning must be used to the greatest extent possible, including online learning methodologies, coaching, mentoring, and simulated skill application.

(c) Content of training delivered by the Child Welfare Training Academy must be informed using multidisciplinary approaches and must include input from stakeholders, including but not limited to child welfare professionals, resource parents, biological parents and caregivers, and other community members with expertise in child welfare racial disparities and implicit bias. Content must be structured to reflect the variety of communities served by the child welfare system in Minnesota and must be informed with attention to both child safety and the evidence-based understanding that maintaining family relationships and preventing out-of-home placement are essential to child well-being. Training delivered by the Child Welfare Training Academy must emphasize racial disparities and disproportionate child welfare outcomes that exist in Minnesota and must include specific content on recognizing and addressing implicit bias.

(d) Each child welfare worker and supervisor must complete a certification, including a competency-based knowledge test and a skills demonstration, at the completion of the worker's or supervisor's initial training and biennially thereafter. The commissioner shall develop ongoing training requirements and a method for tracking certifications.

(e) The Child Welfare Training Academy must serve the primary training audiences of (1) county and tribal child welfare workers, (2) county and tribal child welfare supervisors, and (3) staff at private agencies providing out-of-home placement services for children involved in Minnesota's county and tribal child welfare system.

Subd. 3. **Partnerships.** The commissioner of human services shall enter into a partnership with the University of Minnesota to collaborate in the administration of workforce training.

Subd. 4. **Rulemaking.** The commissioner of human services may adopt rules as necessary to establish the Child Welfare Training Academy.

Sec. 38. **CHILD WELFARE CASELOAD STUDY.**

(a) The commissioner of human services shall conduct a child welfare caseload study to collect data on (1) the number of child welfare workers in Minnesota, and (2) the amount of time that child welfare workers spend on different components of child welfare work. The study must be completed by October 1, 2020.

(b) The commissioner shall report the results of the child welfare caseload study to the governor and to the chairs and ranking minority members of the committees in the house of representatives and senate with jurisdiction over human services by December 1, 2020.

(c) After the child welfare caseload study is complete, the commissioner shall work with counties and other stakeholders to develop a process for ongoing monitoring of child welfare workers' caseloads.

Sec. 39. **DIRECTION TO COMMISSIONER; HOMELESS YOUTH ACCESS TO BIRTH RECORDS AND MINNESOTA IDENTIFICATION CARDS.**

No later than January 15, 2020, the commissioner of human services, in consultation with the commissioners of health and public safety, shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over the Homeless Youth Act with recommendations on providing homeless youth with access to birth records and Minnesota identification cards at no cost.

Sec. 40. **DIRECTION TO COMMISSIONER; FAMILY FIRST PREVENTION KINSHIP SERVICES.**

The commissioner of human services shall review opportunities to implement kinship navigator models that support placement of children with relative foster parents in anticipation of reimbursement for eligible services under the Family First Prevention Services Act.

Kinship navigator models would assist relative foster parents with home studies and licensing requirements and provide ongoing support to the relative caregivers and children in out-of-home placement with relatives.

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

Sec. 41. **DIRECTION TO COMMISSIONER; RELATIVE SEARCH.**

The commissioner of human services shall develop and provide guidance to assist local social services agencies in conducting relative searches under Minnesota Statutes, section 260C.221. The commissioner shall issue a bulletin containing relative search guidance by January 1, 2020. Guidance from the commissioner shall relate to:

(1) easily understandable methods of relative notification;

(2) resources for local social services agency child welfare staff to improve engagement and communication with relatives and kin; and

(3) providing information to relatives and kin about all permanency options, sustaining relationships, visitation options, and supporting permanency.

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

Sec. 42. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with the Department of Human Services, House Research Department, and Senate Counsel, Research and Fiscal Analysis shall change the terms "food support" and "food stamps" to "Supplemental Nutrition Assistance Program" or "SNAP" in Minnesota Statutes when appropriate. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 43. **REPEALER.**

Minnesota Statutes 2018, sections 119B.16, subdivision 2; and 245E.06, subdivisions 2, 4, and 5, and Minnesota Rules, part 3400.0185, subpart 5, are repealed effective February 26, 2021.

ARTICLE 2
OPERATIONS

Section 1. Minnesota Statutes 2018, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated by the welfare system are private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system and an investigator acting on behalf of a county, the state, or the federal government, including a law enforcement person or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; coordinate services for an individual or family; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Employment and Economic Development, and when applicable, the Department of Education, for the following purposes:

(i) to monitor the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency;

(ii) to administer any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system;

(iii) to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, medical programs under chapter 256B or 256L, or a medical program formerly codified under chapter 256D; and

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced-price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a community health board as defined in section 145A.02, subdivision 5, when the commissioner or community health board has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks,

federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, medical programs under chapter 256B or 256L, or a medical program formerly codified under chapter 256D;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions;

(29) counties and the Department of Human Services operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education;

(30) child support data on the child, the parents, and relatives of the child may be disclosed to agencies administering programs under titles IV-B and IV-E of the Social Security Act, as authorized by federal law;

(31) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services;

(32) to the chief administrative officer of a school to coordinate services for a student and family; data that may be disclosed under this clause are limited to name, date of birth, gender, and address; or

(33) to county correctional agencies to the extent necessary to coordinate services and diversion programs; data that may be disclosed under this clause are limited to name, client demographics, program, case status, and county worker information.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

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

Sec. 2. Minnesota Statutes 2018, section 13.46, subdivision 3, is amended to read:

Subd. 3. **Investigative data.** (a) Data on persons, including data on vendors of services, licensees, and applicants that is collected, maintained, used, or disseminated by the welfare system in an investigation, authorized by statute, and relating to the enforcement of rules or law are confidential data on individuals pursuant to section 13.02, subdivision 3, or protected nonpublic data not on individuals pursuant to section 13.02, subdivision 13, and shall not be disclosed except:

(1) pursuant to section 13.05;

(2) pursuant to statute or valid court order;

(3) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense; ~~or~~

(4) to an agent of the welfare system or an investigator acting on behalf of a county, state, or federal government, including a law enforcement officer or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding, unless the commissioner of human services determines that disclosure may compromise a Department of Human Services ongoing investigation; or

~~(4)~~ (5) to provide notices required or permitted by statute.

The data referred to in this subdivision shall be classified as public data upon submission to an administrative law judge or court in an administrative or judicial proceeding. Inactive welfare investigative data shall be treated as provided in section 13.39, subdivision 3.

(b) Notwithstanding any other provision in law, the commissioner of human services shall provide all active and inactive investigative data, including the name of the reporter

of alleged maltreatment under section 626.556 or 626.557, to the ombudsman for mental health and developmental disabilities upon the request of the ombudsman.

(c) Notwithstanding paragraph (a) and section 13.39, the existence of an investigation by the commissioner of human services of possible overpayments of public funds to a service provider or recipient may be disclosed if the commissioner determines that it will not compromise the investigation.

Sec. 3. Minnesota Statutes 2018, 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) Except as provided in item (v), 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 general nature of the complaint or allegations leading to the temporary immediate suspension; the substance and investigative findings of the licensing

or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence of settlement negotiations; 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 a license holder, applicant, or controlling individual is responsible for maltreatment under section 626.556 or 626.557, the identity of the applicant, license holder, or controlling individual 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 a license holder, applicant, or controlling individual is disqualified under chapter 245C, the identity of the license holder, applicant, or controlling individual 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, license holder, or controlling individual 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.

(v) A correction order or fine issued to a child care provider for a licensing violation is private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

(2) 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.

(3) 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 existence of settlement negotiations, 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.

(4) 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.

(5) 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, 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.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 4. Minnesota Statutes 2018, section 13.461, subdivision 28, is amended to read:

Subd. 28. **Child care assistance program.** Data collected, maintained, used, or disseminated by the welfare system pertaining to persons selected as legal nonlicensed child care providers by families receiving child care assistance are classified under section 119B.02, subdivision 6, paragraph (a). Child care assistance program payment data is classified under section 119B.02, subdivision 6, paragraph (b).

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

Sec. 5. Minnesota Statutes 2018, section 15C.02, is amended to read:

15C.02 LIABILITY FOR CERTAIN ACTS.

(a) A person who commits any act described in clauses (1) to (7) is liable to the state or the political subdivision for a civil penalty ~~of not less than $5,500 and not more than $11,000 per false or fraudulent claim~~ in the amounts set forth in the federal False Claims Act, United States Code, title 31, section 3729, and as modified by the federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, plus three times the amount of damages that the state or the political subdivision sustains because of the act of that person, except as otherwise provided in paragraph (b):

(1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(2) knowingly makes or uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(3) knowingly conspires to commit a violation of clause (1), (2), (4), (5), (6), or (7);

(4) has possession, custody, or control of property or money used, or to be used, by the state or a political subdivision and knowingly delivers or causes to be delivered less than all of that money or property;

(5) is authorized to make or deliver a document certifying receipt for money or property used, or to be used, by the state or a political subdivision and, intending to defraud the state or a political subdivision, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a political subdivision who lawfully may not sell or pledge the property; or

(7) knowingly makes or uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a political subdivision, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a political subdivision.

(b) Notwithstanding paragraph (a), the court may assess not less than two times the amount of damages that the state or the political subdivision sustains because of the act of the person if:

(1) the person committing a violation under paragraph (a) furnished an officer or employee of the state or the political subdivision responsible for investigating the false or fraudulent claim violation with all information known to the person about the violation within 30 days after the date on which the person first obtained the information;

(2) the person fully cooperated with any investigation by the state or the political subdivision of the violation; and

(3) at the time the person furnished the state or the political subdivision with information about the violation, no criminal prosecution, civil action, or administrative action had been commenced under this chapter with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation.

(c) A person violating this section is also liable to the state or the political subdivision for the costs of a civil action brought to recover any penalty or damages.

(d) A person is not liable under this section for mere negligence, inadvertence, or mistake with respect to activities involving a false or fraudulent claim.

Sec. 6. Minnesota Statutes 2018, section 16A.055, subdivision 1a, is amended to read:

Subd. 1a. **Additional duties.** The commissioner may assist state agencies by providing analytical, statistical, program evaluation using experimental or quasi-experimental design, and organizational development services to state agencies in order to assist the agency to achieve the agency's mission and to operate efficiently and effectively. For purposes of this section, "experimental design" means a method of evaluating the impact of a service that uses random assignment to assign participants into groups that respectively receive the studied service and those that receive service as usual, so that any difference in outcomes found at the end of the evaluation can be attributed to the studied service; and "quasi-experimental design" means a method of evaluating the impact of a service that uses strategies other than random assignment to establish statistically similar groups that

respectively receive the service and those that receive service as usual, so that any difference in outcomes found at the end of the evaluation can be attributed to the studied service.

Sec. 7. Minnesota Statutes 2018, section 119B.02, subdivision 6, is amended to read:

Subd. 6. **Data.** (a) Data collected, maintained, used, or disseminated by the welfare system pertaining to persons selected as legal nonlicensed child care providers by families receiving child care assistance shall be treated as licensing data as provided in section 13.46, subdivision 4.

(b) For purposes of this paragraph, "child care assistance program payment data" means data for a specified time period showing (1) that a child care assistance program payment under this chapter was made, and (2) the amount of child care assistance payments made to a child care center. Child care assistance program payment data may include the number of families and children on whose behalf payments were made for the specified time period. Any child care assistance program payment data that may identify a specific child care assistance recipient or benefit paid on behalf of a specific child care assistance recipient, as determined by the commissioner, is private data on individuals as defined in section 13.02, subdivision 12. Data related to a child care assistance payment is public if the data relates to a child care assistance payment made to a licensed child care center or a child care center exempt from licensure and:

(1) the child care center receives payment of more than $100,000 from the child care assistance program under this chapter in a period of one year or less; or

(2) when the commissioner or county agency either:

(i) disqualified the center from receipt of a payment from the child care assistance program under this chapter for wrongfully obtaining child care assistance under section 256.98, subdivision 8, paragraph (c);

(ii) refused a child care authorization, revoked a child care authorization, stopped payment, or denied payment for a bill for the center under section 119B.13, subdivision 6, paragraph (d); or

(iii) made a finding of financial misconduct under section 245E.02.

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

Sec. 8. Minnesota Statutes 2018, section 119B.09, subdivision 7, is amended to read:

Subd. 7. **Date of eligibility for assistance.** (a) The date of eligibility for child care assistance under this chapter is the later of the date the application was received by the county; the beginning date of employment, education, or training; the date the infant is born for applicants to the at-home infant care program; or the date a determination has been made that the applicant is a participant in employment and training services under Minnesota Rules, part 3400.0080, or chapter 256J.

(b) Payment ceases for a family under the at-home infant child care program when a family has used a total of 12 months of assistance as specified under section 119B.035. Payment of child care assistance for employed persons on MFIP is effective the date of employment or the date of MFIP eligibility, whichever is later. Payment of child care assistance for MFIP or DWP participants in employment and training services is effective the date of commencement of the services or the date of MFIP or DWP eligibility, whichever is later. Payment of child care assistance for transition year child care must be made retroactive to the date of eligibility for transition year child care.

(c) Notwithstanding paragraph (b), payment of child care assistance for participants eligible under section 119B.05 may only be made retroactive for a maximum of ~~six~~ three months from the date of application for child care assistance.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 119B.125, subdivision 6, is amended to read:

Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must:

(1) keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance; and

~~must~~ (2) make those records available immediately to the county or the commissioner upon request. Any records not provided to a county or the commissioner at the date and time of the request are deemed inadmissible if offered as evidence by the provider in any proceeding to contest an overpayment or disqualification of the provider.

~~The~~ (b) As a condition of payment, attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person

dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

(c) A county or the commissioner may deny or revoke a provider's authorization ~~as a child care provider to any applicant, rescind authorization of any provider,~~ to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a fraud disqualification under section 256.98, take an action against the provider under chapter 245E, or establish an attendance record overpayment ~~claim in the system~~ under paragraph (d) against a current or former provider, when the county or the commissioner knows or has reason to believe that the provider has not complied with the record-keeping requirement in this subdivision. ~~A provider's failure to produce attendance records as requested on more than one occasion constitutes grounds for disqualification as a provider.~~

(d) To calculate an attendance record overpayment under this subdivision, the commissioner or county agency shall subtract the maximum daily rate from the total amount paid to a provider for each day that a child's attendance record is missing, unavailable, incomplete, inaccurate, or otherwise inadequate.

(e) The commissioner shall develop criteria for a county to determine an attendance record overpayment under this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 10. Minnesota Statutes 2018, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

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

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

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

(2) a county or the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

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

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner;

(ii) an order of revocation of the provider's license; or

(iii) a final order of conditional license issued by the commissioner for as long as the conditional license is in effect;

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

(6) the provider gives false child care price information~~.~~; or

(7) the provider fails to report decreases in a child's attendance as required under section 119B.125, subdivision 9.

(e) For purposes of paragraph (d), clauses (3), (5), ~~and~~ (6), and (7), the county or the commissioner may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

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

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers must not be reimbursed for more than 25 full-day absent days per child, excluding holidays, in a ~~fiscal~~ calendar year, or for more than ten consecutive full-day absent days. "Absent day" means any day that the child is authorized and scheduled to be in care with a licensed provider or license-exempt center, and the child is absent from the care for the entire day. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the absent days limit. Child care providers must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Notwithstanding paragraph (a), children with documented medical conditions that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive full-day absent days limit. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the absent days limit in a ~~fiscal~~ calendar year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner.

(c) Notwithstanding paragraph (a), children in families may exceed the absent days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or commissioner of education-selected high school equivalency certification; and (3) is a student in a school district or another similar program that provides or arranges for child care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.

(d) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance.

Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the absent days limit.

(e) A family or child care provider must not be assessed an overpayment for an absent day payment unless (1) there was an error in the amount of care authorized for the family, (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family or provider did not timely report a change as required under law.

(f) The provider and family shall receive notification of the number of absent days used upon initial provider authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.

(g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days per child, excluding holidays, in a ~~fiscal~~ calendar year; and ten consecutive full-day absent days.

(h) For purposes of this subdivision, "holidays limit" means ten full-day holidays per child, excluding absent days, in a calendar year.

(i) If a day meets the criteria of an absent day or a holiday under this subdivision, the provider must bill that day as an absent day or holiday. A provider's failure to properly bill an absent day or a holiday results in an overpayment, regardless of whether the child reached, or is exempt from, the absent days limit or holidays limit for the calendar year.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 144.057, subdivision 3, is amended to read:

Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245C. The commissioner must set aside a disqualification for an individual who requests reconsideration and who meets the criteria described in section 245C.22, subdivision 4, paragraph (d). The commissioner's decision shall be provided to the individual and to the Department of Human Services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action, except for the provisions under sections 245C.25, 245C.27, and 245C.28, subdivision 3.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 13. Minnesota Statutes 2018, section 245.095, is amended to read:

245.095 LIMITS ON RECEIVING PUBLIC FUNDS.

Subdivision 1. **Prohibition.** (a) If a provider, vendor, or individual enrolled, licensed, ~~or~~ receiving funds under a grant contract, or registered in any program administered by the commissioner, including under the commissioner's powers and authorities in section 256.01, is excluded from ~~any~~ that program ~~administered by the commissioner, including under the commissioner's powers and authorities in section 256.01~~, the commissioner shall:

(1) prohibit the excluded provider, vendor, or individual from enrolling ~~or~~, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner~~.~~; and

(2) disenroll, revoke or suspend a license, disqualify, or debar the excluded provider, vendor, or individual in any other program administered by the commissioner.

(b) The duration of this prohibition, disenrollment, revocation, suspension, disqualification, or debarment must last for the longest applicable sanction or disqualifying period in effect for the provider, vendor, or individual permitted by state or federal law.

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions have the meanings given them.

(b) "Excluded" means disenrolled, ~~subject to license revocation or suspension, disqualified, or subject to vendor debarment~~ disqualified, having a license that has been revoked or suspended under chapter 245A, or debarred or suspended under Minnesota Rules, part 1230.1150, or excluded pursuant to section 256B.064, subdivision 3.

(c) "Individual" means a natural person providing products or services as a provider or vendor.

(d) "Provider" ~~means~~ includes any entity or individual receiving payment from a program administered by the Department of Human Services, and an owner, controlling individual, license holder, director, or managerial official of an entity receiving payment from a program administered by the Department of Human Services.

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

Sec. 14. Minnesota Statutes 2018, section 245A.02, subdivision 3, is amended to read:

Subd. 3. **Applicant.** "Applicant" means an individual, ~~corporation, partnership, voluntary association, controlling individual, or other~~ organization, or government entity, as defined in section 13.02, subdivision 7a, that ~~has applied for licensure under this chapter and the~~

~~rules of the commissioner~~ is subject to licensure under this chapter and that has applied for but not yet been granted a license under this chapter.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 15. Minnesota Statutes 2018, section 245A.02, is amended by adding a subdivision to read:

Subd. 3b. **Authorized agent.** "Authorized agent" means the controlling individual designated by the license holder responsible for communicating with the commissioner of human services on all matters related to this chapter and on whom service of all notices and orders must be made pursuant to section 245A.04, subdivision 1.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 16. Minnesota Statutes 2018, section 245A.02, subdivision 8, is amended to read:

Subd. 8. **License.** "License" means a certificate issued by the commissioner under section 245A.04 authorizing the license holder to provide a specified program for a specified period of time and in accordance with the terms of the license and the rules of the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 17. Minnesota Statutes 2018, section 245A.02, subdivision 9, is amended to read:

Subd. 9. **License holder.** "License holder" means an individual, ~~corporation, partnership, voluntary association, or other~~ organization, or government entity that is legally responsible for the operation of the program or service, and has been granted a license by the commissioner under this chapter ~~or chapter 245D~~ and the rules of the commissioner~~, and is a controlling individual~~.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 18. Minnesota Statutes 2018, section 245A.02, is amended by adding a subdivision to read:

Subd. 10c. **Organization.** "Organization" means a domestic or foreign corporation, nonprofit corporation, limited liability company, partnership, limited partnership, limited liability partnership, association, voluntary association, and any other legal or commercial entity. For purposes of this chapter, organization does not include a government entity.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 245A.02, subdivision 12, is amended to read:

Subd. 12. **Private agency.** "Private agency" means an ~~individual, corporation, partnership, voluntary association or other~~ organization, other than a county agency, or a court with jurisdiction, that places persons who cannot remain in their own homes in residential programs, foster care, or adoptive homes. A private agency is designated to perform the commissioner's licensing functions under section 245A.16.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 20. Minnesota Statutes 2018, section 245A.02, subdivision 14, is amended to read:

Subd. 14. **Residential program.** (a) Except as provided in paragraph (b), "residential program" means a program that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training, education, habilitation, or treatment outside a person's own home, including a program in an intermediate care facility for four or more persons with developmental disabilities; and chemical dependency or chemical abuse programs that are located in a hospital or nursing home and receive public funds for providing chemical abuse or chemical dependency treatment services under chapter 254B. ~~Residential programs include home and community-based services for persons with disabilities or persons age 65 and older that are provided in or outside of a person's own home under chapter 245D.~~

(b) For a residential program under chapter 245D, "residential program" means a single or multifamily dwelling that is under the control, either directly or indirectly, of the service provider licensed under chapter 245D and in which at least one person receives services under chapter 245D, including residential supports and services under section 245D.03, subdivision 1, paragraph (c), clause (3); out-of-home crisis respite services under section 245D.03, subdivision 1, paragraph (c), clause (1), item (ii); and out-of-home respite services under section 245D.03, subdivision 1, paragraph (b), clause (1). A residential program does not include out-of-home respite services when a case manager has determined that an unlicensed site meets the assessed needs of the person. A residential program also does not include multifamily dwellings where persons receive integrated community supports, even if authorization to provide these supports is granted under chapter 245D and approved in the federal waiver.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 21. Minnesota Statutes 2018, section 245A.02, subdivision 18, is amended to read:

Subd. 18. **Supervision.** (a) For purposes of licensed child care centers, "supervision" means when a program staff person:

(1) is ~~within sight and hearing of a child at all times so that the program staff~~ accountable for the child's care;

(2) can intervene to protect the health and safety of the child~~.~~; and

(3) is within sight and hearing of the child at all times except as described in paragraphs (b) to (d).

(b) When an infant is placed in a crib room to sleep, supervision occurs when a program staff person is within sight or hearing of the infant. When supervision of a crib room is provided by sight or hearing, the center must have a plan to address the other supervision ~~component~~ components.

(c) When a single school-age child uses the restroom within the licensed space, supervision occurs when a program staff person has knowledge of the child's activity and location and checks on the child at least every five minutes. When a school-age child uses the restroom outside the licensed space, including but not limited to field trips, supervision occurs when staff accompany children to the restroom.

(d) When a school-age child leaves the classroom but remains within the licensed space to deliver or retrieve items from the child's personal storage space, supervision occurs when a program staff person has knowledge of the child's activity and location and checks on the child at least every five minutes.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 22. Minnesota Statutes 2018, section 245A.03, subdivision 1, is amended to read:

Subdivision 1. **License required.** Unless licensed by the commissioner under this chapter, an individual, ~~corporation, partnership, voluntary association, other~~ organization, or ~~controlling individual~~ government entity must not:

(1) operate a residential or a nonresidential program;

(2) receive a child or adult for care, supervision, or placement in foster care or adoption;

(3) help plan the placement of a child or adult in foster care or adoption or engage in placement activities as defined in section 259.21, subdivision 9, in this state, whether or not the adoption occurs in this state; or

(4) advertise a residential or nonresidential program.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 23. Minnesota Statutes 2018, section 245A.03, subdivision 3, is amended to read:

Subd. 3. **Unlicensed programs.** (a) It is a misdemeanor for an individual, ~~corporation, partnership, voluntary association, other~~ organization, or ~~a controlling individual~~ government entity to provide a residential or nonresidential program without a license issued under this chapter and in willful disregard of this chapter unless the program is excluded from licensure under subdivision 2.

(b) The commissioner may ask the appropriate county attorney or the attorney general to begin proceedings to secure a court order against the continued operation of the program, if an individual, ~~corporation, partnership, voluntary association, other~~ organization, or ~~controlling individual~~ government entity has:

(1) failed to apply for a license under this chapter after receiving notice that a license is required or continues to operate without a license after receiving notice that a license is required;

(2) continued to operate without a license after ~~the~~ a license issued under this chapter has been revoked or suspended under ~~section 245A.07~~ this chapter, and the commissioner has issued a final order affirming the revocation or suspension, or the license holder did not timely appeal the sanction; or

(3) continued to operate without a license after ~~the~~ a temporary immediate suspension of a license has been ~~temporarily suspended under section 245A.07~~ issued under this chapter.

(c) The county attorney and the attorney general have a duty to cooperate with the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 24. Minnesota Statutes 2018, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, ~~corporation, partnership, voluntary association, other~~ organization ~~or controlling individual~~, or government entity that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the

applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within 30 miles of the ~~state~~ Minnesota border. An applicant who intends to buy or otherwise acquire a program or services licensed under this chapter that is owned by another license holder must apply for a license under this chapter and comply with the application procedures in this section and section 245A.03.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the ~~information~~ required ~~under section 245C.05~~ information.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05.

(b) An application for licensure must identify all controlling individuals as defined in section 245A.02, subdivision 5a, and must ~~specify an~~ designate one individual to be the authorized agent ~~who is responsible for dealing with the commissioner of human services on all matters provided for in this chapter and on whom service of all notices and orders must be made~~. The application must be signed by the authorized agent and must include the authorized agent's first, middle, and last name; mailing address; and e-mail address. By submitting an application for licensure, the authorized agent consents to electronic communication with the commissioner throughout the application process. The authorized agent must be authorized to accept service on behalf of all of the controlling individuals ~~of the program~~. A government entity that holds multiple licenses under this chapter may designate one authorized agent for all licenses issued under this chapter or may designate a different authorized agent for each license. Service on the authorized agent is service on all of the controlling individuals ~~of the program~~. It is not a defense to any action arising under this chapter that service was not made on each controlling individual ~~of the program~~. The designation of ~~one or more~~ a controlling ~~individuals~~ individual as ~~agents~~ the authorized

agent under this paragraph does not affect the legal responsibility of any other controlling individual under this chapter.

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

(d) An applicant and license holder must have a program grievance procedure that permits persons served by the program and their authorized representatives to bring a grievance to the highest level of authority in the program.

(e) ~~The applicant must be able to demonstrate competent knowledge of the applicable requirements of this chapter and chapter 245C, and the requirements of other licensing statutes and rules applicable to the program or services for which the applicant is seeking to be licensed. Effective January 1, 2013.~~ The commissioner may limit communication during the application process to the authorized agent or the controlling individuals identified on the license application and for whom a background study was initiated under chapter 245C. The commissioner may require the applicant, except for child foster care, to demonstrate competence in the applicable licensing requirements by successfully completing a written examination. The commissioner may develop a prescribed written examination format.

(f) When an applicant is an individual, the ~~individual~~ applicant must provide:

(1) the applicant's taxpayer identification numbers including the Social Security number or Minnesota tax identification number, and federal employer identification number if the applicant has employees;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, if any~~, and~~;

(3) if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state; ~~and~~

~~(3) a notarized signature of the applicant.~~ (4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique Minnesota Provider Identifier (UMPI) number; and

(5) at the request of the commissioner, the notarized signature of the applicant or authorized agent.

(g) When an applicant is ~~a nonindividual~~ an organization, the applicant must provide ~~the~~:

(1) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, and if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state;

(3) the first, middle, and last name, and address for all individuals who will be controlling individuals, including all officers, owners, and managerial officials as defined in section 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant for each controlling individual; ~~and~~

~~(4) first, middle, and last name, mailing address, and notarized signature of the agent authorized by the applicant to accept service on behalf of the controlling individuals.~~

(4) if applicable, the applicant's NPI number and UMPI number;

(5) the documents that created the organization and that determine the organization's internal governance and the relations among the persons that own the organization, have an interest in the organization, or are members of the organization, in each case as provided or authorized by the organization's governing statute, which may include a partnership agreement, bylaws, articles of organization, organizational chart, and operating agreement, or comparable documents as provided in the organization's governing statute; and

(6) the notarized signature of the applicant or authorized agent.

(h) When the applicant is a government entity, the applicant must provide:

(1) the name of the government agency, political subdivision, or other unit of government seeking the license and the name of the program or services that will be licensed;

(2) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(3) a letter signed by the manager, administrator, or other executive of the government entity authorizing the submission of the license application; and

(4) if applicable, the applicant's NPI number and UMPI number.

~~(h)~~ (i) At the time of application for licensure or renewal of a license under this chapter, the applicant or license holder must acknowledge on the form provided by the commissioner if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license that:

(1) the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored by the commissioner as part of a licensing investigation or licensing inspection; and

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

(i) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(ii) nonpayment of claims submitted by the license holder for public program reimbursement;

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

(v) other administrative, civil, or criminal penalties as provided by law.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 25. Minnesota Statutes 2018, section 245A.04, subdivision 2, is amended to read:

Subd. 2. **Notification of affected municipality.** The commissioner must not issue a license under this chapter without giving 30 calendar days' written notice to the affected municipality or other political subdivision unless the program is considered a permitted single-family residential use under sections 245A.11 and 245A.14. The commissioner may provide notice through electronic communication. The notification must be given before the first issuance of a license under this chapter and annually after that time if annual notification is requested in writing by the affected municipality or other political subdivision. State funds must not be made available to or be spent by an agency or department of state, county, or municipal government for payment to a residential or nonresidential program licensed under this chapter until the provisions of this subdivision have been complied with in full. The provisions of this subdivision shall not apply to programs located in hospitals.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 26. Minnesota Statutes 2018, section 245A.04, subdivision 4, is amended to read:

Subd. 4. **Inspections; waiver.** (a) Before issuing ~~an initial~~ a license under this chapter, the commissioner shall conduct an inspection of the program. The inspection must include but is not limited to:

(1) an inspection of the physical plant;

(2) an inspection of records and documents;

~~(3) an evaluation of the program by consumers of the program;~~

~~(4)~~ (3) observation of the program in operation; and

~~(5)~~ (4) an inspection for the health, safety, and fire standards in licensing requirements for a child care license holder.

~~For the purposes of this subdivision, "consumer" means a person who receives the services of a licensed program, the person's legal guardian, or the parent or individual having legal custody of a child who receives the services of a licensed program.~~

(b) The ~~evaluation required in paragraph (a), clause (3), or the~~ observation in paragraph (a), clause ~~(4)~~ (3), is not required prior to issuing ~~an initial~~ a license under subdivision 7. If the commissioner issues ~~an initial~~ a license under ~~subdivision 7~~ this chapter, these requirements must be completed within one year after the issuance of ~~an initial~~ the license.

(c) Before completing a licensing inspection in a family child care program or child care center, the licensing agency must offer the license holder an exit interview to discuss violations or potential violations of law or rule observed during the inspection and offer technical assistance on how to comply with applicable laws and rules. ~~Nothing in this paragraph limits the ability of the commissioner to issue a correction order or negative action for violations of law or rule not discussed in an exit interview or in the event that a license holder chooses not to participate in an exit interview.~~ The commissioner shall not issue a correction order or negative licensing action for violations of law or rule not discussed in an exit interview, unless a license holder chooses not to participate in an exit interview or not to complete the exit interview. If the license holder is unable to complete the exit interview, the licensing agency must offer an alternate time for the license holder to complete the exit interview.

(d) If a family child care license holder disputes a county licensor's interpretation of a licensing requirement during a licensing inspection or exit interview, the license holder may, within five business days after the exit interview or licensing inspection, request clarification from the commissioner, in writing, in a manner prescribed by the commissioner.

The license holder's request must describe the county licensor's interpretation of the licensing requirement at issue, and explain why the license holder believes the county licensor's interpretation is inaccurate. The commissioner and the county must include the license holder in all correspondence regarding the disputed interpretation, and must provide an opportunity for the license holder to contribute relevant information that may impact the commissioner's decision. The county licensor must not issue a correction order related to the disputed licensing requirement until the commissioner has provided clarification to the license holder about the licensing requirement.

~~(d)~~ (e) The commissioner or the county shall inspect at least annually a child care provider licensed under this chapter and Minnesota Rules, chapter 9502 or 9503, for compliance with applicable licensing standards.

~~(e)~~ (f) No later than November 19, 2017, the commissioner shall make publicly available on the department's website the results of inspection reports of all child care providers licensed under this chapter and under Minnesota Rules, chapter 9502 or 9503, and the number of deaths, serious injuries, and instances of substantiated child maltreatment that occurred in licensed child care settings each year.

EFFECTIVE DATE. The amendments to paragraphs (a) and (b) are effective January 1, 2020. The amendments to paragraphs (c) to (f) are effective September 30, 2019.

Sec. 27. Minnesota Statutes 2018, section 245A.04, subdivision 6, is amended to read:

Subd. 6. **Commissioner's evaluation.** (a) Before issuing, denying, suspending, revoking, or making conditional a license, the commissioner shall evaluate information gathered under this section. The commissioner's evaluation shall consider the applicable requirements of statutes and rules for the program or services for which the applicant seeks a license, including the disqualification standards set forth in chapter 245C, and shall evaluate facts, conditions, or circumstances concerning:

(1) the program's operation~~,~~;

(2) the well-being of persons served by the program~~,~~;

(3) available ~~consumer~~ evaluations of the program~~, and~~ by persons receiving services;

(4) information about the qualifications of the personnel employed by the applicant or license holder~~.~~; and

(5) the applicant's or license holder's ability to demonstrate competent knowledge of the applicable requirements of statutes and rules, including this chapter and chapter 245C, for which the applicant seeks a license or the license holder is licensed.

(b) The commissioner shall also evaluate the results of the study required in subdivision 3 and determine whether a risk of harm to the persons served by the program exists. In conducting this evaluation, the commissioner shall apply the disqualification standards set forth in chapter 245C.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 28. Minnesota Statutes 2018, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 245A.043. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue ~~an initial~~ a license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the evaluation or observation required by subdivision 4, paragraph (a), ~~clauses (3) and~~ clause (4), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program. ~~A license shall not be~~

~~transferable to another individual, corporation, partnership, voluntary association, other organization, or controlling individual or to another location.~~

~~(d) A license holder must notify the commissioner and obtain the commissioner's approval before making any changes that would alter the license information listed under paragraph (a).~~

~~(e)~~ (d) Except as provided in paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), the commissioner shall not issue or reissue a license if the applicant, license holder, or controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) been denied a license under this chapter, within the past two years;

(3) had a license issued under this chapter revoked within the past five years;

(4) an outstanding debt related to a license fee, licensing fine, or settlement agreement for which payment is delinquent; or

(5) failed to submit the information required of an applicant under subdivision 1, paragraph (f) or (g), after being requested by the commissioner.

When a license issued under this chapter is revoked under clause (1) or (3), the license holder and controlling individual may not hold any license under chapter 245A ~~or 245D~~ for five years following the revocation, and other licenses held by the applicant, license holder, or controlling individual shall also be revoked.

~~(f)~~ (e) The commissioner shall not issue or reissue a license under this chapter if an individual living in the household where the ~~licensed~~ services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

~~(g)~~ (f) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct

contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

~~(i)~~ (h) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

~~(j)~~ (i) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

~~(k)~~ (j) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a tribal licensing authority has established jurisdiction to license the program or service.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 29. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to read:

Subd. 7a. **Notification required.** (a) A license holder must notify the commissioner, in a manner prescribed by the commissioner, and obtain the commissioner's approval before making any change that would alter the license information listed under subdivision 7, paragraph (a).

(b) A license holder must also notify the commissioner, in a manner prescribed by the commissioner, before making any change:

(1) to the license holder's authorized agent as defined in section 245A.02, subdivision 3b;

(2) to the license holder's controlling individual as defined in section 245A.02, subdivision 5a;

(3) to the license holder information on file with the secretary of state;

(4) in the location of the program or service licensed under this chapter; and

(5) to the federal or state tax identification number associated with the license holder.

(c) When, for reasons beyond the license holder's control, a license holder cannot provide the commissioner with prior notice of the changes in paragraph (b), clauses (1) to (3), the license holder must notify the commissioner by the tenth business day after the change and must provide any additional information requested by the commissioner.

(d) When a license holder notifies the commissioner of a change to the license holder information on file with the secretary of state, the license holder must provide amended articles of incorporation and other documentation of the change.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 30. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to read:

Subd. 9a. **Child foster home variances for capacity.** (a) The commissioner, or the commissioner of corrections under section 241.021, may grant a variance for a licensed family foster parent to allow additional foster children if:

(1) the variance is needed to allow: (i) a parenting youth in foster care to remain with the child of the parenting youth; (ii) siblings to remain together; (iii) a child with an established meaningful relationship with the family to remain with the family; or (iv) a family with special training or skills to provide care to a child who has a severe disability;

(2) there is no risk of harm to a child currently in the home;

(3) the structural characteristics of the home, including sleeping space, accommodates additional foster children;

(4) the home remains in compliance with applicable zoning, health, fire, and building codes; and

(5) the statement of intended use specifies conditions for an exception to capacity limits and specifies how the license holder will maintain a ratio of adults to children that ensures the safety and appropriate supervision of all the children in the home.

(b) A variance granted to a family foster home under Minnesota Rules, part 2960.3030, subpart 3, prior to October 1, 2019, remains in effect until January 1, 2020.

EFFECTIVE DATE. This section is effective October 1, 2019.

Sec. 31. Minnesota Statutes 2018, section 245A.04, subdivision 10, is amended to read:

Subd. 10. **Adoption agency; additional requirements.** In addition to the other requirements of this section, an individual~~, corporation, partnership, voluntary association, other~~ or organization~~, or controlling individual~~ applying for a license to place children for adoption must:

(1) incorporate as a nonprofit corporation under chapter 317A;

(2) file with the application for licensure a copy of the disclosure form required under section 259.37, subdivision 2;

(3) provide evidence that a bond has been obtained and will be continuously maintained throughout the entire operating period of the agency, to cover the cost of transfer of records to and storage of records by the agency which has agreed, according to rule established by the commissioner, to receive the applicant agency's records if the applicant agency voluntarily or involuntarily ceases operation and fails to provide for proper transfer of the records. The bond must be made in favor of the agency which has agreed to receive the records; and

(4) submit a certified audit to the commissioner each year the license is renewed as required under section 245A.03, subdivision 1.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 32. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to read:

Subd. 18. **Plain-language handbook.** By January 1, 2020, the commissioner of human services shall, following consultation with family child care license holders, parents, and county agencies, develop a plain-language handbook that describes the process and requirements to become a licensed family child care provider. The handbook shall include a list of the applicable statutory provisions and rules that apply to licensed family child care providers. The commissioner shall electronically publish the handbook on the Department of Human Services website, available at no charge to the public. Each county human services office and the Department of Human Services shall maintain physical copies of the handbook for public use.

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

Sec. 33. **[245A.043] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.**

Subdivision 1. **Transfer prohibited.** A license issued under this chapter is only valid for a premises and individual, organization, or government entity identified by the commissioner on the license. A license is not transferable or assignable.

Subd. 2. **Change in ownership.** (a) If the commissioner determines that there is a change in ownership, the commissioner shall require submission of a new license application. This subdivision does not apply to a licensed program or service located in a home where the license holder resides. A change in ownership occurs when:

(1) the license holder sells or transfers 100 percent of the property, stock, or assets;

(2) the license holder merges with another organization;

(3) the license holder consolidates with two or more organizations, resulting in the creation of a new organization;

(4) there is a change to the federal tax identification number associated with the license holder; or

(5) all controlling individuals associated with the original application have changed.

(b) Notwithstanding paragraph (a), clauses (1) and (5), no change in ownership has occurred if at least one controlling individual has been listed as a controlling individual for the license for at least the previous 12 months.

Subd. 3. **Change of ownership process.** (a) When a change in ownership is proposed and the party intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service, the license holder must provide the commissioner with written notice of the proposed change on a form provided by the commissioner at least 60 days before the anticipated date of the change in ownership. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change in ownership is complete, and must include documentation to support the upcoming change. The party must comply with background study requirements under chapter 245C and shall pay the application fee required under section 245A.10. A party that intends to assume operation

without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of Minnesota Rules, part 9530.6800.

(c) The commissioner may streamline application procedures when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services the party operates and those licenses are in substantial compliance. For purposes of this subdivision, "substantial compliance" means within the previous 12 months the commissioner did not (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make a license held by the party conditional according to section 245A.06.

(d) Except when a temporary change in ownership license is issued pursuant to subdivision 4, the existing license holder is solely responsible for operating the program according to applicable laws and rules until a license under this chapter is issued to the party.

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's license record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection required by section 245A.04, subdivision 4. The party must submit to the commissioner (1) proof that the premises was inspected by a fire marshal or that the fire marshal deemed that an inspection was not warranted, and (2) proof that the premises was inspected for compliance with the building code or that no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding action under section 245A.06 or 245A.07, the party must submit a letter as part of the application process identifying how the party has or will come into full compliance with the licensing requirements.

(g) The commissioner shall evaluate the party's application according to section 245A.04, subdivision 6. If the commissioner determines that the party has remedied or demonstrates the ability to remedy the outstanding actions under section 245A.06 or 245A.07 and has determined that the program otherwise complies with all applicable laws and rules, the commissioner shall issue a license or conditional license under this chapter. The conditional license remains in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner may deny an application as provided in section 245A.05. An applicant whose application was denied by the commissioner may appeal the denial according to section 245A.05.

(i) This subdivision does not apply to a licensed program or service located in a home where the license holder resides.

Subd. 4. **Temporary change in ownership license.** (a) After receiving the party's application pursuant to subdivision 3, upon the written request of the existing license holder and the party, the commissioner may issue a temporary change in ownership license to the party while the commissioner evaluates the party's application. Until a decision is made to grant or deny a license under this chapter, the existing license holder and the party shall both be responsible for operating the program or service according to applicable laws and rules, and the sale or transfer of the existing license holder's ownership interest in the licensed program or service does not terminate the existing license.

(b) The commissioner may issue a temporary change in ownership license when a license holder's death, divorce, or other event affects the ownership of the program and an applicant seeks to assume operation of the program or service to ensure continuity of the program or service while a license application is evaluated.

(c) This subdivision applies to any program or service licensed under this chapter.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 34. Minnesota Statutes 2018, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

(a) The commissioner may deny a license if an applicant or controlling individual:

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 245A.04, subdivision 1;

(2) fails to comply with applicable laws or rules;

(3) knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation;

(4) has a disqualification that has not been set aside under section 245C.22 and no variance has been granted;

(5) has an individual living in the household who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(6) is associated with an individual who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to children or vulnerable adults, and who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted; ~~or~~

(7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g)~~.~~;

(8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision 6;

(9) has a history of noncompliance as a license holder or controlling individual with applicable laws or rules, including but not limited to this chapter and chapters 119B and 245C; or

(10) is prohibited from holding a license according to section 245.095.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail or personal service. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 35. **[245A.055] CLOSING A LICENSE.**

Subdivision 1. **Inactive programs.** The commissioner may close a license if the commissioner determines that a licensed program has not been serving any client for a consecutive period of 12 months or longer. The license holder is not prohibited from reapplying for a license if the license holder's license was closed under this chapter.

Subd. 2. **Reconsideration of closure.** If a license is closed, the commissioner must notify the license holder of closure by certified mail or personal service. If mailed, the notice of closure must be mailed to the last known address of the license holder and must inform the license holder why the license was closed and that the license holder has the right to request reconsideration of the closure. If the license holder believes that the license was

closed in error, the license holder may ask the commissioner to reconsider the closure. The license holder's request for reconsideration must be made in writing and must include documentation that the licensed program has served a client in the previous 12 months. The request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder receives the notice of closure. A timely request for reconsideration stays imposition of the license closure until the commissioner issues a decision on the request for reconsideration.

Subd. 3. **Reconsideration final.** The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 36. Minnesota Statutes 2018, section 245A.07, subdivision 1, is amended to read:

Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional under section 245A.06, the commissioner may suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. When applying sanctions authorized under this section, the commissioner shall consider 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.

(b) If a license holder appeals the suspension or revocation of a license and the license holder continues to operate the program pending a final order on the appeal, the commissioner shall issue the license holder a temporary provisional license. Unless otherwise specified by the commissioner, variances in effect on the date of the license sanction under appeal continue under the temporary provisional license. If a license holder fails to comply with applicable law or rule while operating under a temporary provisional license, the commissioner may impose additional sanctions under this section and section 245A.06, and may terminate any prior variance. If a temporary provisional license is set to expire, a new temporary provisional license shall be issued to the license holder upon payment of any fee required under section 245A.10. The temporary provisional license shall expire on the date the final order is issued. If the license holder prevails on the appeal, a new nonprovisional license shall be issued for the remainder of the current license period.

(c) If a license holder is under investigation and the license issued under this chapter is due to expire before completion of the investigation, the program shall be issued a new license upon completion of the reapplication requirements and payment of any applicable

license fee. Upon completion of the investigation, a licensing sanction may be imposed against the new license under this section, section 245A.06, or 245A.08.

(d) Failure to reapply or closure of a license issued under this chapter by the license holder prior to the completion of any investigation shall not preclude the commissioner from issuing a licensing sanction under this section~~,~~ or section 245A.06~~, or 245A.08~~ at the conclusion of the investigation.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 37. Minnesota Statutes 2018, section 245A.07, subdivision 2, is amended to read:

Subd. 2. **Temporary immediate suspension.** (a) The commissioner shall act immediately to temporarily suspend a license issued under this chapter if:

(1) the license holder's actions or failure to comply with applicable law or rule, or the actions of other individuals or conditions in the program, pose an imminent risk of harm to the health, safety, or rights of persons served by the program; ~~or~~

(2) while the program continues to operate pending an appeal of an order of revocation, the commissioner identifies one or more subsequent violations of law or rule which may adversely affect the health or safety of persons served by the program~~.~~; or

(3) the license holder is criminally charged in state or federal court with an offense that involves fraud or theft against a program administered by the commissioner.

(b) No state funds shall be made available or be expended by any agency or department of state, county, or municipal government for use by a license holder regulated under this chapter while a license issued under this chapter is under immediate suspension. A notice stating the reasons for the immediate suspension and informing the license holder of the right to an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612, must be delivered by personal service to the address shown on the application or the last known address of the license holder. The license holder may appeal an order immediately suspending a license. The appeal of an order immediately suspending a license must be made in writing by certified mail ~~or~~, personal service, or other means expressly set forth in the commissioner's order. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice that the license has been immediately suspended. If a request is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. A license holder and any controlling individual shall discontinue operation of the program upon receipt of the commissioner's order to immediately suspend the license.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 38. Minnesota Statutes 2018, section 245A.07, subdivision 2a, is amended to read:

Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses, or the actions of other individuals or conditions in the program poses an imminent risk of harm to the health, safety, or rights of persons served by the program. "Reasonable cause" means there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of persons served by the program. When the commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, as defined in section 245A.1435, the commissioner is not required to demonstrate that an infant died or was injured as a result of the safe sleep violations. For suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration by a preponderance of the evidence that, since the license was revoked, the license holder committed additional violations of law or rule which may adversely affect the health or safety of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten working days from the close of the record. When an appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner

shall issue a final order affirming the temporary immediate suspension within ten calendar days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall make a determination regarding whether a final licensing sanction shall be issued under subdivision 3. The license holder shall continue to be prohibited from operation of the program during this 90-day period.

(c) When the final order under paragraph (b) affirms an immediate suspension, and a final licensing sanction is issued under subdivision 3 and the license holder appeals that sanction, the license holder continues to be prohibited from operation of the program pending a final commissioner's order under section 245A.08, subdivision 5, regarding the final licensing sanction.

(d) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration by a preponderance of the evidence that a criminal complaint and warrant or summons was issued for the license holder that was not dismissed, and that the criminal charge is an offense that involves fraud or theft against a program administered by the commissioner.

Sec. 39. Minnesota Statutes 2018, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules including but not limited to the requirements of this chapter and chapter 245C;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has ~~a~~ been disqualified and the disqualification ~~which has~~ was not ~~been~~ set aside ~~under section 245C.22~~ and no variance has been granted;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules; ~~or~~

(4) ~~after July 1, 2012, and upon request by the commissioner, a license holder fails to submit the information required of an applicant under section 245A.04, subdivision 1,~~

~~paragraph (f) or (g).~~ a license holder is excluded from any program administered by the commissioner under section 245.095; or

(5) revocation is required under section 245A.04, subdivision 7, paragraph (d).

A license holder who has had a license issued under this chapter suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state in plain language the reasons the license was suspended or revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the

license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

(i) the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c);

(ii) if the commissioner determines that a determination of maltreatment for which the license holder is responsible is the result of maltreatment that meets the definition of serious maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit $5,000;

(iii) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to ~~9502.0495~~ 9502.0445, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

(iv) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(v) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine in items (i) to (iv).

For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide home and community-based services, as identified in section 245D.03, subdivision 1, and a community residential setting or day services facility license under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 40. Minnesota Statutes 2018, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family day care homes.** Nonresidential child care programs serving 14 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family day care or group family day care if:

(a) the license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling that is located on a residential lot;

(b) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(c) the license holder is a church or religious organization;

(d) the license holder is a community collaborative child care provider. For purposes of this subdivision, a community collaborative child care provider is a provider participating in a cooperative agreement with a community action agency as defined in section 256E.31;

(e) the license holder is a not-for-profit agency that provides child care in a dwelling located on a residential lot and the license holder maintains two or more contracts with community employers or other community organizations to provide child care services. The county licensing agency may grant a capacity variance to a license holder licensed under this paragraph to exceed the licensed capacity of 14 children by no more than five

children during transition periods related to the work schedules of parents, if the license holder meets the following requirements:

(1) the program does not exceed a capacity of 14 children more than a cumulative total of four hours per day;

(2) the program meets a one to seven staff-to-child ratio during the variance period;

(3) all employees receive at least an extra four hours of training per year than required in the rules governing family child care each year;

(4) the facility has square footage required per child under Minnesota Rules, part 9502.0425;

(5) the program is in compliance with local zoning regulations;

(6) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code ~~2003~~ 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code ~~2003~~ 2015, Section 202, unless the rooms in which the children are cared for are located on a level of exit discharge and each of these child care rooms has an exit door directly to the exterior, then the applicable fire code is Group E occupancies, as provided in the Minnesota State Fire Code 2015, Section 202; and

(7) any age and capacity limitations required by the fire code inspection and square footage determinations shall be printed on the license; or

(f) the license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:

(1) the program is in compliance with local zoning regulations;

(2) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code ~~2003~~ 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code ~~2003~~ 2015, Section 202;

(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center."

(g) The commissioner may approve two or more licenses under paragraphs (a) to (f) to be issued at the same location or under one contiguous roof, if each license holder is able to demonstrate compliance with all applicable rules and laws. Each license holder must operate the license holder's respective licensed program as a distinct program and within the capacity, age, and ratio distributions of each license.

(h) The commissioner may grant variances to this section to allow a primary provider of care, a not-for-profit organization, a church or religious organization, an employer, or a community collaborative to be licensed to provide child care under paragraphs (e) and (f) if the license holder meets the other requirements of the statute.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 41. Minnesota Statutes 2018, section 245A.14, subdivision 8, is amended to read:

Subd. 8. **Experienced aides; child care centers.** (a) An individual employed as an aide at a child care center may work with children without being directly supervised for an amount of time that does not exceed 25 percent of the child care center's daily hours if:

(1) a teacher is in the facility;

~~(2) the individual has received within the last three years first aid training that meets the requirements under section 245A.40, subdivision 3, and CPR training that meets the requirements under section 245A.40, subdivision 4;~~

~~(3)~~ (2) the individual is at least 20 years old; and

~~(4)~~ (3) the individual has at least 4,160 hours of child care experience as a staff member in a licensed child care center or as the license holder of a family day care home, 120 days of which must be in the employment of the current company.

(b) A child care center that uses experienced aides under this subdivision must notify parents or guardians by posting the notification in each classroom that uses experienced

aides, identifying which staff member is the experienced aide. Records of experienced aide usage must be kept on site and given to the commissioner upon request.

(c) A child care center may not use the experienced aide provision for one year following two determined experienced aide violations within a one-year period.

(d) A child care center may use one experienced aide per every four full-time child care classroom staff.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 42. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to read:

Subd. 16. **Valid driver's license.** Notwithstanding any law to the contrary, when a licensed child care center provides transportation for children or contracts to provide transportation for children, a person who has a current, valid driver's license appropriate to the vehicle driven may transport the child.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 43. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to read:

Subd. 17. **Reusable water bottles or cups.** Notwithstanding any law to the contrary, a licensed child care center may provide drinking water to a child in a reusable water bottle or reusable cup if the center develops and ensures implementation of a written policy that at a minimum includes the following procedures:

(1) each day the water bottle or cup is used, the child care center cleans and sanitizes the water bottle or cup using procedures that comply with the Food Code under Minnesota Rules, chapter 4626;

(2) a water bottle or cup is assigned to a specific child and labeled with the child's first and last name;

(3) water bottles and cups are stored in a manner that reduces the risk of a child using the wrong water bottle or cup; and

(4) a water bottle or cup is used only for water.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 44. Minnesota Statutes 2018, section 245A.145, subdivision 1, is amended to read:

Subdivision 1. **Policies and procedures.** (a) ~~All licensed child care providers~~ The Department of Human Services must develop policies and procedures for reporting suspected child maltreatment that fulfill the requirements in section 626.556 and ~~must develop policies and procedures for reporting complaints about the operation of a child care program. The policies and procedures must include the telephone numbers of the local county child protection agency for reporting suspected maltreatment; the county licensing agency for family and group family child care providers; and the state licensing agency for child care centers.~~ provide the policies and procedures to all licensed child care providers. The policies and procedures must be written in plain language.

(b) The policies and procedures required in paragraph (a) must:

(1) be provided to the parents of all children at the time of enrollment in the child care program; and

(2) be made available upon request.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 45. Minnesota Statutes 2018, section 245A.145, subdivision 2, is amended to read:

Subd. 2. **Licensing agency phone number displayed.** ~~By July 1, 2002,~~ A new or renewed child care license must include the licensing agency's telephone number and a statement that informs parents who have ~~concerns~~ questions about their child's care that they may call the licensing agency. ~~The commissioner shall print the telephone number for the licensing agency in bold and large font on the license issued to child care providers.~~

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

Sec. 46. **[245A.149] SUPERVISION OF FAMILY CHILD CARE LICENSE HOLDER'S OWN CHILD.**

(a) Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, an individual may be present in the licensed space, may supervise the family child care license holder's own child both inside and outside of the licensed space, and is exempt from the training and supervision requirements of this chapter and Minnesota Rules, chapter 9502, if the individual:

(1) is related to the license holder, as defined in section 245A.02, subdivision 13;

(2) is not a designated caregiver, helper, or substitute for the licensed program;

(3) is involved only in the care of the license holder's own child; and

(4) does not have direct, unsupervised contact with any nonrelative children receiving services.

(b) If the individual in paragraph (a) is not a household member, the individual is also exempt from background study requirements under chapter 245C.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 47. Minnesota Statutes 2018, section 245A.151, is amended to read:

245A.151 FIRE MARSHAL INSPECTION.

When licensure under this chapter or certification under chapter 245H requires an inspection by a fire marshal to determine compliance with the State Fire Code under section 299F.011, a local fire code inspector approved by the state fire marshal may conduct the inspection. If a community does not have a local fire code inspector or if the local fire code inspector does not perform the inspection, the state fire marshal must conduct the inspection. A local fire code inspector or the state fire marshal may recover the cost of these inspections through a fee of no more than $50 per inspection charged to the applicant or license holder or license-exempt child care center certification holder. The fees collected by the state fire marshal under this section are appropriated to the commissioner of public safety for the purpose of conducting the inspections.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 48. Minnesota Statutes 2018, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that, before the implementation of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment;

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours; ~~and~~

(7) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder~~.~~; and

(8) variances to section 245A.53 for a time-limited period. If the commissioner grants a variance under this clause, the license holder must provide notice of the variance to all parents and guardians of the children in care.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family child care programs, the commissioner shall require a county agency to conduct one unannounced licensing review at least annually.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

(f) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

(g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and private agencies.

(h) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing review completed, including the date of the review, and any licensing correction order issued; ~~and~~

(2) any death, serious injury, or determination of substantiated maltreatment~~.~~; and

(3) any fires that require the service of a fire department within 48 hours of the fire. The information under this clause must also be reported to the State Fire Marshal within two business days of receiving notice from a licensed family child care provider.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 49. Minnesota Statutes 2018, section 245A.18, subdivision 2, is amended to read:

Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs licensed by the Department of Human Services under Minnesota Rules, chapter 2960, that serve a child or children under ~~nine~~ eight years of age must document training that fulfills the requirements in this subdivision.

(b) Before a license holder, staff person, or caregiver transports a child or children under age ~~nine~~ eight in a motor vehicle, the person transporting the child must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this section may be used to meet initial or ongoing training under Minnesota Rules, part 2960.3070, subparts 1 and 2.

~~For all providers licensed prior to July 1, 2006, the training required in this subdivision must be obtained by December 31, 2007.~~

(c) Training required under this section must be ~~at least one hour in length,~~ completed at orientation or initial training~~,~~ and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(d) Training under paragraph (c) must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

~~(e) Child care providers that only transport school age children as defined in section 245A.02, subdivision 16, in school buses as defined in section 169.011, subdivision 71, paragraphs (c) to (f), are exempt from this subdivision.~~

(e) Notwithstanding paragraph (a), for an emergency relative placement under section 245A.035, the commissioner may grant a variance to the training required by this subdivision for a relative who completes a child seat safety check up. The child seat safety check up trainer must be approved by the Department of Public Safety, Office of Traffic Safety, and must provide one-on-one instruction on placing a child of a specific age in the exact child passenger restraint in the motor vehicle in which the child will be transported. Once granted a variance, and if all other licensing requirements are met, the relative applicant may receive a license and may transport a relative foster child younger than eight years of age. A child seat safety check up must be completed each time a child requires a different size car seat according to car seat and vehicle manufacturer guidelines. A relative license holder must complete training that meets the other requirements of this subdivision prior to placement of another foster child younger than eight years of age in the home or prior to the renewal of the child foster care license.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 50. **[245A.24] MANDATORY REPORTING.**

Any individual engaging in licensing functions and activities under this chapter, including authorities delegated under section 245A.16, must immediately report any suspected fraud to county human services investigators or the Department of Human Services Office of Inspector General.

Sec. 51. Minnesota Statutes 2018, section 245A.40, is amended to read:

245A.40 CHILD CARE CENTER TRAINING REQUIREMENTS.

Subdivision 1. **Orientation.** (a) The child care center license holder must ensure that ~~every~~ the director, staff ~~person and volunteer is~~ persons, substitutes, and unsupervised volunteers are given orientation training and successfully ~~completes~~ complete the training before starting assigned duties. ~~The orientation training in this subdivision applies to volunteers who will have direct contact with or access to children and who are not under the direct supervision of a staff person. Completion of the orientation must be documented in the individual's personnel record.~~ The orientation training must include information about:

(1) the center's philosophy, child care program, and procedures for maintaining health and safety according to section 245A.41 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) specific job responsibilities;

(3) the behavior guidance standards in Minnesota Rules, part 9503.0055; ~~and~~

(4) the reporting responsibilities in section 626.556, and Minnesota Rules, part 9503.0130~~.~~;

(5) the center's drug and alcohol policy under section 245A.04, subdivision 1, paragraph (c);

(6) the center's risk reduction plan as required under section 245A.66, subdivision 2;

(7) at least one-half hour of training on the standards under section 245A.1435 and on reducing the risk of sudden unexpected infant death as required in subdivision 5, if applicable;

(8) at least one-half hour of training on the risk of abusive head trauma as required for the director and staff under subdivision 5a, if applicable; and

(9) training required by a child's individual child care program plan as required under Minnesota Rules, part 9503.0065, subpart 3, if applicable.

(b) In addition to paragraph (a), before having unsupervised direct contact with a child, the director and staff persons within the first 90 days of employment, and substitutes and unsupervised volunteers within 90 days after the first date of direct contact with a child, must complete:

(1) pediatric first aid, in accordance with subdivision 3; and

(2) pediatric cardiopulmonary resuscitation, in accordance with subdivision 4.

(c) In addition to paragraph (b), the director and staff persons within the first 90 days of employment, and substitutes and unsupervised volunteers within 90 days from the first date of direct contact with a child, must complete training in child development, in accordance with subdivision 2.

(d) The license holder must ensure that documentation, as required in subdivision 10, identifies the number of hours completed for each topic with a minimum training time identified, if applicable, and that all required content is included.

(e) Training in this subdivision must not be used to meet in-service training requirements in subdivision 7.

(f) Training completed within the previous 12 months under paragraphs (a), clauses (7) and (8), and (c) are transferable to another child care center.

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

(b) "Substitute" means an adult who is temporarily filling a position as a director, teacher, assistant teacher, or aide in a licensed child care center for less than 240 hours total in a calendar year due to the absence of a regularly employed staff person.

(c) "Staff person" means an employee of a child care center who provides direct contact services to children.

(d) "Unsupervised volunteer" means an individual who:

(1) assists in the care of a child in care;

(2) is not under the continuous direct supervision of a staff person; and

(3) is not employed by the child care center.

Subd. 2. **Child development and learning training.** (a) ~~For purposes of child care centers,~~ The director and all staff ~~hired after July 1, 2006,~~ persons, substitutes, and unsupervised volunteers shall complete ~~and document at least two hours of~~ child development and learning training within the first 90 days of employment. The director and staff persons, not including substitutes, must complete at least two hours of training on child development and learning. The training for substitutes and unsupervised volunteers is not required to be of a minimum length. For purposes of this subdivision, "child development and learning training" means any training in Knowledge and Competency Area I: Child Development and Learning, which is training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and

community. ~~Training completed under this subdivision may be used to meet the in-service training requirements under subdivision 7.~~

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

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

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

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

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

(c) The director and staff persons, not including substitutes, must complete at least two hours of child development and learning training every second calendar year.

(d) Substitutes and unsupervised volunteers must complete child development and learning training every second calendar year. There is no minimum number of training hours required.

(e) Except for training required under paragraph (a), training completed under this subdivision may be used to meet the in-service training requirements under subdivision 7.

Subd. 3. **First aid.** (a) ~~All teachers and assistant teachers in a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during field trips and when transporting children in care, must satisfactorily complete pediatric first aid training within 90 days of the start of work, unless the training has been completed within the previous two years.~~ Unless training has been completed within the previous two years, the director, staff persons, substitutes, and unsupervised volunteers must satisfactorily complete pediatric first aid training prior to having unsupervised direct contact with a child, but not to exceed the first 90 days of employment.

(b) ~~Notwithstanding paragraph (a), which allows 90 days to complete training, at least one staff person who has satisfactorily completed pediatric first aid training must be present at all times in the center, during field trips, and when transporting children in care.~~ Pediatric first aid training must be repeated at least every second calendar year. First aid training under this subdivision must be provided by an individual approved as a first aid instructor and must not be used to meet in-service training requirements under subdivision 7.

~~(c) The pediatric first aid training must be repeated at least every two years, documented in the person's personnel record and indicated on the center's staffing chart, and provided by an individual approved as a first aid instructor. This training may be less than eight hours.~~

Subd. 4. **Cardiopulmonary resuscitation.** ~~(a) All teachers and assistant teachers in a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during field trips and when transporting children in care, must satisfactorily complete training in cardiopulmonary resuscitation (CPR) that includes CPR techniques for infants and children and in the treatment of obstructed airways. The CPR training must be completed within 90 days of the start of work, unless the training has been completed within the previous two years. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once every two years, and must be documented in the staff person's records.~~

~~(b) Notwithstanding paragraph (a), which allows 90 days to complete training, at least one staff person who has satisfactorily completed cardiopulmonary resuscitation training must be present at all times in the center, during field trips, and when transporting children in care.~~

~~(c) CPR training may be provided for less than four hours.~~

~~(d) Persons providing CPR training must use CPR training that has been developed:~~

~~(1) by the American Heart Association or the American Red Cross and incorporates psychomotor skills to support the instruction; or~~

~~(2) using nationally recognized, evidence-based guidelines for CPR and incorporates psychomotor skills to support the instruction.~~

(a) Unless training has been completed within the previous two years, the director, staff persons, substitutes, and unsupervised volunteers must satisfactorily complete pediatric cardiopulmonary resuscitation (CPR) training that meets the requirements of this subdivision. Pediatric CPR training must be completed prior to having unsupervised direct contact with a child, but not to exceed the first 90 days of employment.

(b) Pediatric CPR training must be provided by an individual approved to provide pediatric CPR instruction.

(c) The Pediatric CPR training must:

(1) cover CPR techniques for infants and children and the treatment of obstructed airways;

(2) include instruction, hands-on practice, and an in-person, observed skills assessment under the direct supervision of a CPR instructor; and

(3) be developed by the American Heart Association, the American Red Cross, or another organization that uses nationally recognized, evidence-based guidelines for CPR.

(d) Pediatric CPR training must be repeated at least once every second calendar year.

(e) Pediatric CPR training in this subdivision must not be used to meet in-service training requirements under subdivision 7.

Subd. 5. **Sudden unexpected infant death ~~and abusive head trauma~~ training.** (a) Before caring for infants, the director, staff persons, substitutes, unsupervised volunteers, and any other volunteers must receive training on the standards under section 245A.1435 and on reducing the risk of sudden unexpected infant death during orientation and each calendar year thereafter.

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

(c) Except if completed during orientation, training taken under this subdivision may be used to meet the in-service training requirements under subdivision 7.

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

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

~~holder communication with parents regarding reducing the risk of sudden unexpected infant death.~~

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

(c) Except if completed during orientation, training taken under this subdivision may be used to meet the in-service training requirements under subdivision 7.

(d) The commissioner shall make available for viewing a video presentation on the dangers associated with shaking infants and young children, which may be used in conjunction with the annual training required under paragraph ~~(c)~~ (a).

Subd. 6. **Child passenger restraint systems; ~~training requirement.~~** ~~(a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685. (b) Child care centers that serve a child or children under nine years of age must document training that fulfills the requirements in this subdivision.~~

~~(1)~~ (a) Before a license holder transports a child or children under age ~~nine~~ eight in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. ~~Training completed under this subdivision may be used to meet orientation training under subdivision 1 and in-service training under subdivision 7.~~

~~(2)~~ (b) Training required under this subdivision must be ~~at least one hour in length, completed at orientation, and~~ repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

~~(3)~~ (c) Training required under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

~~(4)~~ (d) Child care providers that only transport school-age children as defined in section 245A.02, subdivision 16, in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

(e) Training completed under this subdivision may be used to meet in-service training requirements under subdivision 7. Training completed within the previous five years is transferable upon a staff person's change in employment to another child care center.

Subd. 7. **In-service.** (a) A license holder must ensure that the center director ~~and all staff who have direct contact with a child complete annual in-service training. In-service training requirements must be met by a staff person's participation in the following training areas:~~, staff persons, substitutes, and unsupervised volunteers complete in-service training each calendar year.

(b) The center director and staff persons who work more than 20 hours per week must complete 24 hours of in-service training each calendar year. Staff persons who work 20 hours or less per week must complete 12 hours of in-service training each calendar year. Substitutes and unsupervised volunteers must complete the requirements of paragraphs (e) to (h) and do not otherwise have a minimum number of hours of training to complete.

(c) The number of in-service training hours may be prorated for individuals not employed for an entire year.

(d) Each year, in-service training must include:

(1) the center's procedures for maintaining health and safety according to section 245A.41 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) the reporting responsibilities under section 626.556 and Minnesota Rules, part 9503.0130;

(3) at least one-half hour of training on the standards under section 245A.1435 and on reducing the risk of sudden unexpected infant death as required under subdivision 5, if applicable; and

(4) at least one-half hour of training on the risk of abusive head trauma from shaking infants and young children as required under subdivision 5a, if applicable.

(e) Each year, or when a change is made, whichever is more frequent, in-service training must be provided on: (1) the center's risk reduction plan under section 245A.66, subdivision 2; and (2) a child's individual child care program plan as required under Minnesota Rules, part 9503.0065, subpart 3.

(f) At least once every two calendar years, the in-service training must include:

(1) child development and learning training under subdivision 2;

(2) pediatric first aid that meets the requirements of subdivision 3;

(3) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 4;

(4) cultural dynamics training to increase awareness of cultural differences; and

(5) disabilities training to increase awareness of differing abilities of children.

(g) At least once every five years, in-service training must include child passenger restraint training that meets the requirements of subdivision 6, if applicable.

(h) The remaining hours of the in-service training requirement must be met by completing training in the following content areas of the Minnesota Knowledge and Competency Framework:

(1) Content area I: child development and learning;

(2) Content area II: developmentally appropriate learning experiences;

(3) Content area III: relationships with families;

(4) Content area IV: assessment, evaluation, and individualization;

(5) Content area V: historical and contemporary development of early childhood education;

(6) Content area VI: professionalism; ~~and~~

(7) Content area VII: health, safety, and nutrition; and

(8) Content area VIII: application through clinical experiences.

~~(b)~~ (i) For purposes of this subdivision, the following terms have the meanings given them.

(1) "Child development and learning training" ~~has the meaning given it in subdivision 2, paragraph (a).~~ means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community.

(2) "Developmentally appropriate learning experiences" means creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, and promoting creative development.

(3) "Relationships with families" means training on building a positive, respectful relationship with the child's family.

(4) "Assessment, evaluation, and individualization" means training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality.

(5) "Historical and contemporary development of early childhood education" means training in past and current practices in early childhood education and how current events and issues affect children, families, and programs.

(6) "Professionalism" means training in knowledge, skills, and abilities that promote ongoing professional development.

(7) "Health, safety, and nutrition" means training in establishing health practices, ensuring safety, and providing healthy nutrition.

(8) "Application through clinical experiences" means clinical experiences in which a person applies effective teaching practices using a range of educational programming models.

~~(c) The director and all program staff persons must annually complete a number of hours of in-service training equal to at least two percent of the hours for which the director or program staff person is annually paid, unless one of the following is applicable.~~

~~(1) A teacher at a child care center must complete one percent of working hours of in-service training annually if the teacher:~~

~~(i) possesses a baccalaureate or master's degree in early childhood education or school-age care;~~

~~(ii) is licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or~~

~~(iii) possesses a baccalaureate degree with a Montessori certificate.~~

~~(2) A teacher or assistant teacher at a child care center must complete one and one-half percent of working hours of in-service training annually if the individual is:~~

~~(i) a registered nurse or licensed practical nurse with experience working with infants;~~

~~(ii) possesses a Montessori certificate, a technical college certificate in early childhood development, or a child development associate certificate; or~~

~~(iii) possesses an associate of arts degree in early childhood education, a baccalaureate degree in child development, or a technical college diploma in early childhood development.~~

~~(d) The number of required training hours may be prorated for individuals not employed full time or for an entire year.~~

~~(e) The annual in-service training must be completed within the calendar year for which it was required. In-service training completed by staff persons is transferable upon a staff person's change in employment to another child care program.~~

~~(f)~~ (j) The license holder must ensure that~~, when a staff person completes in-service training, the training is documented in the staff person's personnel record. The documentation must include the date training was completed, the goal of the training and topics covered, trainer's name and organizational affiliation, trainer's signed statement that training was successfully completed,~~ documentation, as required in subdivision 10, includes the number of total training hours required to be completed, name of the training, the Minnesota Knowledge and Competency Framework content area, number of hours completed, and the director's approval of the training.

(k) In-service training completed by a staff person that is not specific to that child care center is transferable upon a staff person's change in employment to another child care program.

~~Subd. 8. **Cultural dynamics and disabilities training for child care providers.** (a) The training required of licensed child care center staff must include training in the cultural dynamics of early childhood development and child care. The cultural dynamics and disabilities training and skills development of child care providers must be designed to achieve outcomes for providers of child care that include, but are not limited to:~~

~~(1) an understanding and support of the importance of culture and differences in ability in children's identity development;~~

~~(2) understanding the importance of awareness of cultural differences and similarities in working with children and their families;~~

~~(3) understanding and support of the needs of families and children with differences in ability;~~

~~(4) developing skills to help children develop unbiased attitudes about cultural differences and differences in ability;~~

~~(5) developing skills in culturally appropriate caregiving; and~~

~~(6) developing skills in appropriate caregiving for children of different abilities.~~

~~(b) Curriculum for cultural dynamics and disability training shall be approved by the commissioner.~~

~~(c) The commissioner shall amend current rules relating to the training of the licensed child care center staff to require cultural dynamics training. Timelines established in the rule amendments for complying with the cultural dynamics training requirements must be based on the commissioner's determination that curriculum materials and trainers are available statewide.~~

~~(d) For programs caring for children with special needs, the license holder shall ensure that any additional staff training required by the child's individual child care program plan required under Minnesota Rules, part 9503.0065, subpart 3, is provided.~~

~~Subd. 9. **Ongoing health and safety training.** A staff person's orientation training on maintaining health and safety and handling emergencies and accidents, as required in subdivision 1, must be repeated at least once each calendar year by each staff person. The completion of the annual training must be documented in the staff person's personnel record.~~

Subd. 10. **Documentation.** All training must be documented and maintained on site in each personnel record. In addition to any requirements for each training provided in this section, documentation for each staff person must include the staff person's first date of direct contact and first date of unsupervised contact with a child in care.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 52. Minnesota Statutes 2018, section 245A.41, is amended to read:

245A.41 CHILD CARE CENTER HEALTH AND SAFETY REQUIREMENTS.

Subdivision 1. **Allergy prevention and response.** (a) Before admitting a child for care, the license holder must obtain documentation of any known allergy from the child's parent or legal guardian or the child's source of medical care. If a child has a known allergy, the license holder must maintain current information about the allergy in the child's record and develop an individual child care program plan as specified in Minnesota Rules, part 9503.0065, subpart 3. The individual child care program plan must include but not be limited to a description of the allergy, specific triggers, avoidance techniques, symptoms of an allergic reaction, and procedures for responding to an allergic reaction, including medication, dosages, and a doctor's contact information.

(b) The license holder must ensure that each staff person who is responsible for carrying out the individual child care program plan review and follow the plan. Documentation of a staff person's review must be kept on site.

(c) At least ~~annually~~ once each calendar year or following any changes made to allergy-related information in the child's record, the license holder must update the child's individual child care program plan and inform each staff person who is responsible for carrying out the individual child care program plan of the change. The license holder must keep on site documentation that a staff person was informed of a change.

(d) A child's allergy information must be available at all times including on site, when on field trips, or during transportation. A child's food allergy information must be readily available to a staff person in the area where food is prepared and served to the child.

(e) The license holder must contact the child's parent or legal guardian as soon as possible in any instance of exposure or allergic reaction that requires medication or medical intervention. The license holder must call emergency medical services when epinephrine is administered to a child in the license holder's care.

Subd. 2. **Handling and disposal of bodily fluids.** The licensed child care center must comply with the following procedures for safely handling and disposing of bodily fluids:

(1) surfaces that come in contact with potentially infectious bodily fluids, including blood and vomit, must be cleaned and disinfected according to Minnesota Rules, part 9503.0005, subpart 11;

(2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

(3) sharp items used for a child with special care needs must be disposed of in a "sharps container." The sharps container must be stored out of reach of a child;

(4) the license holder must have the following bodily fluid disposal supplies in the center: disposable gloves, disposal bags, and eye protection; and

(5) the license holder must ensure that each staff person ~~is trained on~~ follows universal precautions to reduce the risk of spreading infectious disease. ~~A staff person's completion of the training must be documented in the staff person's personnel record.~~

Subd. 3. **Emergency preparedness.** (a) ~~No later than September 30, 2017,~~ A licensed child care center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to a child. The plan must be written on a form developed by the commissioner and must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, relocation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; ~~and~~

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities; and

(8) accommodations for infants and toddlers.

(b) The license holder must train staff persons on the emergency plan at orientation, when changes are made to the plan, and at least once each calendar year. Training must be documented in each staff person's personnel file.

(c) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

(d) The license holder must review and update the emergency plan annually. Documentation of the annual emergency plan review shall be maintained in the program's administrative records.

(e) The license holder must include the emergency plan in the program's policies and procedures as specified under section 245A.04, subdivision 14. The license holder must provide a physical or electronic copy of the emergency plan to the child's parent or legal guardian upon enrollment.

(f) The relocation site and evacuation route must be posted in a visible place as part of the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140, subpart 21.

Subd. 4. **Child passenger restraint requirements.** A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

Subd. 5. **Telephone requirement in licensed child care centers.** (a) A working telephone which is capable of making outgoing calls and receiving incoming calls must be located within the licensed child care center at all times. Staff must have access to a working telephone while providing care and supervision to children in care, even if the care occurs outside of the child care facility. A license holder may use a cellular telephone to meet the requirements of this subdivision.

(b) If a cellular telephone is used to satisfy the requirements of this subdivision, the cellular telephone must be accessible to staff, be stored in a centrally located area when not in use, and be sufficiently charged for use at all times.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 53. Minnesota Statutes 2018, section 245A.50, subdivision 1, is amended to read:

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

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

(c) Training requirements established under this section that must be completed prior to initial licensure must be satisfied only by a newly licensed child care provider or by a child care provider who has not held an active child care license in Minnesota in the previous 12 months. A child care provider ~~who relocates within the state or~~ who voluntarily cancels a license or allows the license to lapse for a period of less than 12 months and who seeks reinstatement of the lapsed or canceled license within 12 months of the lapse or cancellation must satisfy the annual, ongoing training requirements, and is not required to satisfy the training requirements that must be completed prior to initial licensure. A child care provider who relocates within the state must (1) satisfy the annual, ongoing training requirements according to the schedules established in this section and (2) not be required to satisfy the training requirements under this section that the child care provider completed prior to initial licensure. If a licensed provider moves to a new county, the new county is prohibited from requiring the provider to complete any orientation class or training for new providers.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 54. Minnesota Statutes 2018, section 245A.51, subdivision 3, is amended to read:

Subd. 3. **Emergency preparedness plan.** (a) ~~No later than September 30, 2017,~~ A licensed family child care provider must have a written emergency preparedness plan for emergencies that require evacuation, sheltering, or other protection of children, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to children. The plan must be written on a form developed by the commissioner and updated at least annually. The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitate easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; ~~and~~

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities; and

(8) accommodations for infants and toddlers.

(b) The license holder must train caregivers before the caregiver provides care and at least annually on the emergency preparedness plan and document completion of this training.

(c) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

(d) The license holder must have the emergency preparedness plan available for review ~~and posted in a prominent location. The license holder must provide a physical or electronic copy of the plan to the child's parent or legal guardian upon enrollment~~.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 55. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision to read:

Subd. 4. **Transporting children.** A license holder must ensure compliance with all seat belt and child passenger restraint system requirements under section 169.685.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 56. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision to read:

Subd. 5. **Telephone requirement.** Notwithstanding Minnesota Rules, part 9502.0435, subpart 8, item B, a license holder is not required to post a list of emergency numbers. A license holder may use a cellular telephone to meet the requirements of Minnesota Rules, part 9502.0435, subpart 8, if the cellular telephone is sufficiently charged for use at all times.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 57. **[245A.52] FAMILY CHILD CARE PHYSICAL SPACE REQUIREMENTS.**

Subdivision 1. **Means of escape.** (a)(1) At least one emergency escape route separate from the main exit from the space must be available in each room used for sleeping by anyone receiving licensed care, and (2) a basement used for child care. One means of escape must be a stairway or door leading to the floor of exit discharge. The other must be a door or window leading directly outside. A window used as an emergency escape route must be openable without special knowledge.

(b) In homes with construction that began before May 2, 2016, the interior of the window leading directly outside must have a net clear opening area of not less than 4.5 square feet or 648 square inches and have minimum clear opening dimensions of 20 inches wide and 20 inches high. The opening must be no higher than 48 inches from the floor. The height to the window may be measured from a platform if a platform is located below the window.

(c) In homes with construction that began on or after May 2, 2016, the interior of the window leading directly outside must have minimum clear opening dimensions of 20 inches wide and 24 inches high. The net clear opening dimensions shall be the result of normal operation of the opening. The opening must be no higher than 44 inches from the floor.

(d) Additional requirements are dependent on the distance of the openings from the ground outside the window: (1) windows or other openings with a sill height not more than 44 inches above or below the finished ground level adjacent to the opening (grade-floor emergency escape and rescue openings) must have a minimum opening of five square feet; and (2) non-grade floor emergency escape and rescue openings must have a minimum opening of 5.7 square feet.

Subd. 2. **Door to attached garage.** Notwithstanding Minnesota Rules, part 9502.0425, subpart 5, day care residences with an attached garage are not required to have a self-closing door to the residence. The door to the residence may be a steel insulated door if the door is at least 1-3/8 inches thick.

Subd. 3. **Heating and venting systems.** Notwithstanding Minnesota Rules, part 9502.0425, subpart 7, items that can be ignited and support combustion, including but not limited to plastic, fabric, and wood products must not be located within 18 inches of a gas or fuel-oil heater or furnace. If a license holder produces manufacturer instructions listing a smaller distance, then the manufacturer instructions control the distance combustible items must be from gas, fuel-oil, or solid-fuel burning heaters or furnaces.

Subd. 4. **Fire extinguisher.** A portable, operational, multipurpose, dry chemical fire extinguisher with a minimum 2 A 10 BC rating must be located in or near the kitchen and

cooking areas of the residence at all times. The fire extinguisher must be serviced annually by a qualified inspector. All caregivers must know how to properly use the fire extinguisher.

Subd. 5. **Carbon monoxide and smoke alarms.** (a) All homes must have an approved and operational carbon monoxide alarm installed within ten feet of each room used for sleeping children in care.

(b) Smoke alarms that have been listed by the Underwriter Laboratory must be properly installed and maintained on all levels including basements, but not including crawl spaces and uninhabitable attics, and in hallways outside rooms used for sleeping children in care.

(c) In homes with construction that began on or after May 2, 2016, smoke alarms must be installed and maintained in each room used for sleeping children in care.

Subd. 6. **Updates.** After readoption of the Minnesota State Fire Code, the fire marshal must notify the commissioner of any changes that conflict with this section and Minnesota Rules, chapter 9502. The state fire marshal must identify necessary statutory changes to align statutes with the revised code. The commissioner must recommend updates to sections of chapter 245A that are derived from the Minnesota State Fire Code in the legislative session following readoption of the code.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 58. **[245A.53] SUBSTITUTE CAREGIVERS AND REPLACEMENTS IN FAMILY CHILD CARE.**

Subdivision 1. **Total hours allowed.** Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, the use of a substitute caregiver in a licensed family child care program must be limited to a cumulative total of not more than 500 hours annually. The license holder must document the name, dates, and number of hours of the substitute who provided care.

Subd. 2. **Emergency replacement supervision.** (a) A license holder may allow an adult who has not completed the training requirements under this chapter or the background study requirements under chapter 245C to supervise children in a family child care program in an emergency. For purposes of this subdivision, an emergency is a situation in which:

(1) the license holder has begun operating the family child care program for the day and for reasons beyond the license holder's control, including, but not limited to a serious illness or injury, accident, or situation requiring the license holder's immediate attention, the license holder needs to leave the licensed space and close the program for the day; and

(2) the parents or guardians of the children attending the program are contacted to pick up their children as soon as is practicable.

(b) The license holder must make reasonable efforts to minimize the time the emergency replacement has unsupervised contact with the children in care, not to exceed 24 hours per emergency incident.

(c) The license holder shall not knowingly use a person as an emergency replacement who has committed an action or has been convicted of a crime that would cause the person to be disqualified from providing care to children, if a background study was conducted under chapter 245C.

(d) To the extent practicable, the license holder must attempt to arrange for emergency care by a substitute caregiver before using an emergency replacement.

(e) To the extent practicable, the license holder must notify the county licensing agency within seven days that an emergency replacement was used, and specify the circumstances that led to the use of the emergency replacement. The county licensing agency must notify the commissioner within three business days after receiving the license holder's notice that an emergency replacement was used, and specify the circumstances that led to the use of the emergency replacement.

(f) Notwithstanding the requirements in Minnesota Rules, part 9502.0405, a license holder is not required to provide the names of persons who may be used as replacements in emergencies to parents or the county licensing agency.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 59. Minnesota Statutes 2018, section 245A.66, subdivision 2, is amended to read:

Subd. 2. **Child care centers; risk reduction plan.** (a) Child care centers licensed under this chapter and Minnesota Rules, chapter 9503, must develop a risk reduction plan that identifies the general risks to children served by the child care center. The license holder must establish procedures to minimize identified risks, train staff on the procedures, and annually review the procedures.

(b) The risk reduction plan must include an assessment of risk to children the center serves or intends to serve and identify specific risks based on the outcome of the assessment. The assessment of risk must be based on the following:

(1) an assessment of the risks presented by the physical plant where the licensed services are provided, including an evaluation of the following factors: the condition and design of

the facility and its outdoor space, bathrooms, storage areas, and accessibility of medications and cleaning products that are harmful to children when children are not supervised and the existence of areas that are difficult to supervise; and

(2) an assessment of the risks presented by the environment for each facility and for each site, including an evaluation of the following factors: the type of grounds and terrain surrounding the building and the proximity to hazards, busy roads, and publicly accessed businesses.

(c) The risk reduction plan must include a statement of measures that will be taken to minimize the risk of harm presented to children for each risk identified in the assessment required under paragraph (b) related to the physical plant and environment. At a minimum, the stated measures must include the development and implementation of specific policies and procedures or reference to existing policies and procedures that minimize the risks identified.

(d) In addition to any program-specific risks identified in paragraph (b), the plan must include development and implementation of specific policies and procedures or refer to existing policies and procedures that minimize the risk of harm or injury to children, including:

(1) closing children's fingers in doors, including cabinet doors;

(2) leaving children in the community without supervision;

(3) children leaving the facility without supervision;

(4) caregiver dislocation of children's elbows;

(5) burns from hot food or beverages, whether served to children or being consumed by caregivers, and the devices used to warm food and beverages;

(6) injuries from equipment, such as scissors and glue guns;

(7) sunburn;

(8) feeding children foods to which they are allergic;

(9) children falling from changing tables; and

(10) children accessing dangerous items or chemicals or coming into contact with residue from harmful cleaning products.

(e) The plan shall prohibit the accessibility of hazardous items to children.

(f) The plan must include specific policies and procedures to ensure adequate supervision of children at all times as defined under section 245A.02, subdivision 18, with particular emphasis on:

(1) times when children are transitioned from one area within the facility to another;

(2) nap-time supervision, including infant crib rooms as specified under section 245A.02, subdivision 18, which requires that when an infant is placed in a crib to sleep, supervision occurs when a staff person is within sight or hearing of the infant. When supervision of a crib room is provided by sight or hearing, the center must have a plan to address the other supervision components;

(3) child drop-off and pick-up times;

(4) supervision during outdoor play and on community activities, including but not limited to field trips and neighborhood walks; ~~and~~

(5) supervision of children in hallways~~.~~; and

(6) supervision of school-age children when using the restroom and visiting the child's personal storage space.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 60. Minnesota Statutes 2018, section 245A.66, subdivision 3, is amended to read:

Subd. 3. **~~Orientation to~~ Yearly review of risk reduction plan ~~and annual review of plan.~~** ~~(a) The license holder shall ensure that all mandated reporters, as defined in section 626.556, subdivision 3, who are under the control of the license holder, receive an orientation to the risk reduction plan prior to first providing unsupervised direct contact services, as defined in section 245C.02, subdivision 11, to children, not to exceed 14 days from the first supervised direct contact, and annually thereafter. The license holder must document the orientation to the risk reduction plan in the mandated reporter's personnel records.~~

~~(b)~~ The license holder must review the risk reduction plan ~~annually~~ each calendar year and document the ~~annual~~ review. When conducting the review, the license holder must consider incidents that have occurred in the center since the last review, including:

(1) the assessment factors in the plan;

(2) the internal reviews conducted under this section, if any;

(3) substantiated maltreatment findings, if any; and

(4) incidents that caused injury or harm to a child, if any, that occurred since the last review.

Following any change to the risk reduction plan, the license holder must inform ~~mandated reporters~~ staff persons, under the control of the license holder, of the changes in the risk reduction plan, and document that the ~~mandated reporters~~ staff were informed of the changes.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 61. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

Subd. 5a. **License-exempt child care center certification holder.** "License-exempt child care center certification holder" has the meaning given for "certification holder" in section 245H.01, subdivision 4.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 62. Minnesota Statutes 2018, section 245C.02, subdivision 6a, is amended to read:

Subd. 6a. **Child care background study subject.** (a) "Child care background study subject" means an individual who is affiliated with a licensed child care center, certified license exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B, and who is:

(1) ~~who is~~ employed by a child care provider for compensation;

(2) ~~whose activities involve~~ assisting in the ~~supervision~~ care of a child for a child care provider; ~~or~~

~~(3) who is required to have a background study under section 245C.03, subdivision 1.~~

(3) a person applying for licensure, certification, or enrollment;

(4) a controlling individual as defined in section 245A.02, subdivision 5a;

(5) an individual 13 years of age or older who lives in the household where the licensed program will be provided and who is not receiving licensed services from the program;

(6) an individual ten to 12 years of age who lives in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) an individual who, without providing direct contact services at a licensed program, certified program, or program authorized under chapter 119B, may have unsupervised access

to a child receiving services from a program when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15; or

(8) a volunteer, contractor, prospective employee, or other individual who has unsupervised physical access to a child served by a program and who is not under supervision by an individual listed in clause (1) or (5), regardless of whether the individual provides program services.

(b) Notwithstanding paragraph (a), an individual who is providing services that are not part of the child care program is not required to have a background study if:

(1) the child receiving services is signed out of the child care program for the duration that the services are provided;

(2) the licensed child care center, certified license exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B has obtained advanced written permission from the parent authorizing the child to receive the services, which is maintained in the child's record;

(3) the licensed child care center, certified license exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B maintains documentation on-site that identifies the individual service provider and the services being provided; and

(4) the licensed child care center, certified license exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B ensures that the service provider does not have unsupervised access to a child not receiving the provider's services.

Sec. 63. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

Subd. 6b. **Children's residential facility.** "Children's residential facility" means a children's residential facility licensed by the commissioner of corrections or the commissioner of human services under Minnesota Rules, chapter 2960.

EFFECTIVE DATE. This section is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 64. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

Subd. 20. **Substance use disorder treatment field.** "Substance use disorder treatment field" means a program exclusively serving individuals 18 years of age and older and that is required to be:

(1) licensed under chapter 245G; or

(2) registered under section 157.17 as a board and lodge establishment that predominantly serves individuals being treated for or recovering from a substance use disorder.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 65. Minnesota Statutes 2018, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) all controlling individuals as defined in section 245A.02, subdivision 5a; ~~and~~

(8) notwithstanding the other requirements in this subdivision, child care background study subjects as defined in section 245C.02, subdivision 6a~~.~~; and

(9) notwithstanding clause (3), for children's residential facilities, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

~~(b) Paragraph (a), clauses (2), (5), and (6), apply to legal nonlicensed child care and certified license-exempt child care programs.~~

~~(c)~~ (b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

Sec. 66. Minnesota Statutes 2018, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study results to county and private agencies for background studies conducted by the commissioner for child foster care; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

Sec. 67. Minnesota Statutes 2018, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (b), for background studies conducted by the commissioner for child foster care, children's residential facilities, 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 for a national criminal history record check.

(b) For background studies initiated on or after the implementation of NETStudy 2.0, except as provided under subdivision 5a, every subject of a background study must provide the commissioner with a set of the background study subject's classifiable fingerprints and photograph. The photograph and fingerprints must be recorded at the same time by the commissioner's authorized fingerprint collection vendor and sent to the commissioner through the commissioner's secure data system described in section 245C.32, subdivision 1a, paragraph (b).

(c) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal Apprehension and, when specifically required by law, submitted to the Federal Bureau of Investigation for a national criminal history record check.

(d) The fingerprints must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will ~~only retain fingerprints of subjects with a criminal history~~ not retain background study subjects' fingerprints.

(e) The commissioner's authorized fingerprint collection vendor shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor shall retain no more than the name and date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(f) For any background study conducted under this chapter, the subject shall provide the commissioner with a set of classifiable fingerprints when the commissioner has reasonable cause to require a national criminal history record check as defined in section 245C.02, subdivision 15a.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 68. Minnesota Statutes 2018, section 245C.05, subdivision 5a, is amended to read:

Subd. 5a. **Background study requirements for minors.** (a) A background study completed under this chapter on a subject who is required to be studied under section 245C.03, subdivision 1, and is 17 years of age or younger shall be completed by the commissioner for:

(1) a legal nonlicensed child care provider authorized under chapter 119B;

(2) a licensed family child care program; or

(3) a licensed foster care home.

(b) The subject shall submit to the commissioner only the information under subdivision 1, paragraph (a).

(c) A subject who is 17 years of age or younger is required to submit fingerprints and a photograph, and the commissioner shall conduct a national criminal history record check, if:

(1) the commissioner has reasonable cause to require a national criminal history record check defined in section 245C.02, subdivision 15a; or

(2) under paragraph (a), clauses (1) and (2), the subject is employed by the provider or supervises children served by the program.

(d) A subject who is 17 years of age or younger is required to submit non-fingerprint-based data according to section 245C.08, subdivision 1, paragraph (a), clause (6), item (iii), and the commissioner shall conduct the check if:

(1) the commissioner has reasonable cause to require a national criminal history record check defined in section 245C.02, subdivision 15a; or

(2) the subject is employed by the provider or supervises children served by the program under paragraph (a), clauses (1) and (2).

Sec. 69. Minnesota Statutes 2018, 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 received as a result of submission of fingerprints for a national criminal history record check, as defined in section 245C.02, subdivision 13c, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245C.02, subdivision 15a, or as required under section 144.057, subdivision 1, clause (2);

(6) for a background study related to a child foster care application for licensure, children's residential facilities, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a background study required for family child care, certified license-exempt child care, child care centers, and legal nonlicensed child care authorized under chapter 119B, 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) when the background study subject is 18 years of age or older, or a minor under section 245C.05, subdivision 5a, paragraph (c), information received following submission of fingerprints for a national criminal history record check; and

(iii) when the background study subject is 18 years of age or older or a minor under section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified license-exempt child care, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B, information obtained using non-fingerprint-based data including information from the criminal and sex offender registries for any state in which the background study subject resided for the past five years and information from the national crime information database and the national sex offender registry; and

(7) for a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care authorized under

chapter 119B, the background study shall also include, to the extent practicable, a name and date-of-birth search of the National Sex Offender Public website.

(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.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 70. Minnesota Statutes 2018, section 245C.08, subdivision 3, is amended to read:

Subd. 3. **Arrest and investigative information.** (a) For any background study completed under this section, if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the ~~commissioner~~ commissioners of health and human services;

(3) a county attorney;

(4) a county sheriff;

(5) a county agency;

(6) a local chief of police;

(7) other states;

(8) the courts;

(9) the Federal Bureau of Investigation;

(10) the National Criminal Records Repository; and

(11) criminal records from other states.

(b) Except when specifically required by law, the commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the ~~license holder who~~ entity that initiated the background study.

(c) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the data obtained is private data and cannot be shared with county agencies, private agencies, or prospective employers of the background study subject.

(d) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the license holder or entity that submitted the study is not required to obtain a copy of the background study subject's disqualification letter under section 245C.17, subdivision 3.

EFFECTIVE DATE. This section is effective for background studies requested on or after October 1, 2019.

Sec. 71. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision to read:

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

EFFECTIVE DATE. This section is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 72. Minnesota Statutes 2018, section 245C.13, subdivision 2, is amended to read:

Subd. 2. **Direct contact pending completion of background study.** The subject of a background study may not perform any activity requiring a background study under paragraph ~~(b)~~ (c) until the commissioner has issued one of the notices under paragraph (a).

(a) Notices from the commissioner required prior to activity under paragraph (b) include:

(1) a notice of the study results under section 245C.17 stating that:

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study;

(2) a notice that a disqualification has been set aside under section 245C.23; or

(3) a notice that a variance has been granted related to the individual under section 245C.30.

(b) For a background study affiliated with a licensed child care center or certified license exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must require the individual to be under continuous direct supervision prior to completion of the background study except as permitted in subdivision 3.

(c) Activities prohibited prior to receipt of notice under paragraph (a) include:

(1) being issued a license;

(2) living in the household where the licensed program will be provided;

(3) providing direct contact services to persons served by a program unless the subject is under continuous direct supervision; ~~or~~

(4) having access to persons receiving services if the background study was completed under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2), (5), or (6), unless the subject is under continuous direct supervision~~.~~; or

(5) for licensed child care center and certified license exempt child care centers, providing direct contact services to persons served by the program.

Sec. 73. Minnesota Statutes 2018, section 245C.13, is amended by adding a subdivision to read:

Subd. 3. **Other state information.** If the commissioner has not received criminal, sex offender, or maltreatment information from another state that is required to be reviewed under this chapter within ten days of requesting the information, and the lack of the information is the only reason that a notice is issued under subdivision 2, paragraph (a), clause (1), item (ii), the commissioner may issue a notice under subdivision 2, paragraph (a), clause (1), item (i). The commissioner may take action on information received from other states after issuing a notice under subdivision 2, paragraph (a), clause (1), item (ii).

Sec. 74. Minnesota Statutes 2018, section 245C.22, subdivision 4, is amended to read:

Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the applicant, license holder, or other entities as provided in this chapter.

(b) In determining whether the individual has met the burden of proof by demonstrating the individual does not pose a risk of harm, the commissioner shall consider:

(1) the nature, severity, and consequences of the event or events that led to the disqualification;

(2) whether there is more than one disqualifying event;

(3) the age and vulnerability of the victim at the time of the event;

(4) the harm suffered by the victim;

(5) vulnerability of persons served by the program;

(6) the similarity between the victim and persons served by the program;

(7) the time elapsed without a repeat of the same or similar event;

(8) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and

(9) any other information relevant to reconsideration.

(c) If the individual requested reconsideration on the basis that the information relied upon to disqualify the individual was incorrect or inaccurate and the commissioner determines that the information relied upon to disqualify the individual is correct, the commissioner

must also determine if the individual poses a risk of harm to persons receiving services in accordance with paragraph (b).

(d) For an individual seeking employment in the substance use disorder treatment field, the commissioner shall set aside the disqualification if the following criteria are met:

(1) the individual is not disqualified for a crime of violence as listed under section 624.712, subdivision 5, except for the following crimes: crimes listed under section 152.021, subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

(2) the individual is not disqualified under section 245C.15, subdivision 1;

(3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph (b);

(4) the individual provided documentation of successful completion of treatment, at least one year prior to the date of the request for reconsideration, at a program licensed under chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after the successful completion of treatment;

(5) the individual provided documentation demonstrating abstinence from controlled substances, as defined in section 152.01, subdivision 4, for the period of one year prior to the date of the request for reconsideration; and

(6) the individual is seeking employment in the substance use disorder treatment field.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 75. Minnesota Statutes 2018, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the substance use disorder field, if the commissioner has previously set aside an individual's disqualification for one or more programs or agencies in the substance use disorder treatment field, and the individual is the subject of a subsequent background study for a different program or agency in the substance use disorder treatment field, the commissioner shall set aside the disqualification for the program or agency in the substance use disorder treatment field that initiated the subsequent background study when the criteria under paragraph (b), clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified in section 254C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued within 15 working days.

~~(c)~~ (d) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 76. Minnesota Statutes 2018, section 245C.24, subdivision 1, is amended to read:

Subdivision 1. **Minimum disqualification periods.** The disqualification periods under subdivisions 3 ~~and 4~~ to 5 are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure because the individual continues to pose a risk of harm to persons served by that individual, even after the minimum disqualification period has passed.

EFFECTIVE DATE. This section is effective March 1, 2020.

Sec. 77. Minnesota Statutes 2018, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in ~~paragraph~~ paragraphs (b)~~,~~ to (e), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual in the chemical dependency or corrections field who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a variance pursuant to section 245C.30 for the license holder for a program dealing primarily with adults. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service.

(c) If an individual who requires a background study for nonemergency medical transportation services under section 245C.03, subdivision 12, was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have passed since the discharge of the sentence imposed, the commissioner may consider granting a set aside pursuant to section 245C.22. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the employer. This paragraph does not apply to a person disqualified based on a violation of sections 243.166; 609.185 to 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3, clause (1); 617.246; or 617.247.

~~(c)~~ (d) When a licensed foster care provider adopts an individual who had received foster care services from the provider for over six months, and the adopted individual is required to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause

(2) or (6), the commissioner may grant a variance to the license holder under section 245C.30 to permit the adopted individual with a permanent disqualification to remain affiliated with the license holder under the conditions of the variance when the variance is recommended by the county of responsibility for each of the remaining individuals in placement in the home and the licensing agency for the home.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 78. Minnesota Statutes 2018, section 245C.24, is amended by adding a subdivision to read:

Subd. 5. **Five-year bar to set aside disqualification; children's residential facilities.** The commissioner shall not set aside the disqualification of an individual in connection with a license for a children's residential facility who was convicted of a felony within the past five years for: (1) physical assault or battery; or (2) a drug-related offense.

EFFECTIVE DATE. This section is effective for background studies initiated on or after July 1, 2019.

Sec. 79. Minnesota Statutes 2018, section 245C.30, subdivision 1, is amended to read:

Subdivision 1. **License holder and license-exempt child care center certification holder variance.** (a) Except for any disqualification under section 245C.15, subdivision 1, when the commissioner has not set aside a background study subject's disqualification, and there are conditions under which the disqualified individual may provide direct contact services or have access to people receiving services that minimize the risk of harm to people receiving services, the commissioner may grant a time-limited variance to a license holder or license-exempt child care center certification holder.

(b) The variance shall state the reason for the disqualification, the services that may be provided by the disqualified individual, and the conditions with which the license holder, license-exempt child care center certification holder, or applicant must comply for the variance to remain in effect.

(c) Except for programs licensed to provide family child care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the variance must be requested by the license holder or license-exempt child care center certification holder.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 80. Minnesota Statutes 2018, section 245C.30, subdivision 2, is amended to read:

Subd. 2. **Disclosure of reason for disqualification.** (a) The commissioner may not grant a variance for a disqualified individual unless the applicant, license-exempt child care center certification holder, or license holder requests the variance and the disqualified individual provides written consent for the commissioner to disclose to the applicant, license-exempt child care center certification holder, or license holder the reason for the disqualification.

(b) This subdivision does not apply to programs licensed to provide family child care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home. When the commissioner grants a variance for a disqualified individual in connection with a license to provide the services specified in this paragraph, the disqualified individual's consent is not required to disclose the reason for the disqualification to the license holder in the variance issued under subdivision 1, provided that the commissioner may not disclose the reason for the disqualification if the disqualification is based on a felony-level conviction for a drug-related offense within the past five years.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 81. Minnesota Statutes 2018, section 245C.30, subdivision 3, is amended to read:

Subd. 3. **Consequences for failing to comply with conditions of variance.** When a license holder or license-exempt child care center certification holder permits a disqualified individual to provide any services for which the subject is disqualified without complying with the conditions of the variance, the commissioner may terminate the variance effective immediately and subject the license holder to a licensing action under sections 245A.06 and 245A.07 or a license-exempt child care center certification holder to an action under sections 245H.06 and 245H.07.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 82. Minnesota Statutes 2018, section 245E.02, is amended by adding a subdivision to read:

Subd. 1a. **Provider definitions.** For the purposes of this section, "provider" includes:

(1) individuals or entities meeting the definition of provider in section 245E.01, subdivision 12; and

(2) owners and controlling individuals of entities identified in clause (1).

Sec. 83. Minnesota Statutes 2018, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **Care coordination provider qualifications.** (a) Care coordination must be provided by qualified staff. An individual is qualified to provide care coordination if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed 30 hours of classroom instruction on care coordination for an individual with substance use disorder;

(4) has either:

(i) a bachelor's degree in one of the behavioral sciences or related fields; or

(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and

(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.

(b) A care coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor ~~weekly~~, or a mental health professional who has substance use treatment and assessments within the scope of their practice, on a monthly basis.

Sec. 84. Minnesota Statutes 2018, section 245G.19, subdivision 4, is amended to read:

Subd. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of a child, the license holder must meet the following standards:

(1) child and adult ratios in Minnesota Rules, part 9502.0367;

(2) day care training in section 245A.50;

(3) behavior guidance in Minnesota Rules, part 9502.0395;

(4) activities and equipment in Minnesota Rules, part 9502.0415;

(5) physical environment in Minnesota Rules, part 9502.0425; ~~and~~

(6) physical space requirements in section 245A.52; and

(7) water, food, and nutrition in Minnesota Rules, part 9502.0445, unless the license holder has a license from the Department of Health.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 85. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

Subd. 7. **Substitute.** "Substitute" means an adult who is temporarily filling a position as a staff person for less than 240 hours total in a calendar year due to the absence of a regularly employed staff person who provides direct contact services to a child.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 86. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

Subd. 8. **Staff person.** "Staff person" means an employee of a certified center who provides direct contact services to children.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 87. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

Subd. 9. **Unsupervised volunteer.** "Unsupervised volunteer" means an individual who: (1) assists in the care of a child in care; (2) is not under the continuous direct supervision of a staff person; and (3) is not employed by the certified center.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 88. Minnesota Statutes 2018, section 245H.03, is amended by adding a subdivision to read:

Subd. 4. **Reconsideration of certification denial.** (a) The applicant may request reconsideration of the denial by notifying the commissioner by certified mail or personal service. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the order. If a request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the order. The applicant may submit with the request for reconsideration a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 89. Minnesota Statutes 2018, section 245H.07, is amended to read:

245H.07 DECERTIFICATION.

Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification holder:

(1) failed to comply with an applicable law or rule; ~~or~~

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules~~.~~; or

(3) has authorization to receive child care assistance payments revoked pursuant to chapter 119B.

(b) When considering decertification, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule.

(c) When a center is decertified, the center is ineligible to receive a child care assistance payment under chapter 119B.

Subd. 2. **Reconsideration of decertification.** (a) The certification holder may request reconsideration of the decertification by notifying the commissioner by certified mail or personal service. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within 20 calendar days after the certification holder received the order. If a request is made by personal service, it must be received by the commissioner within 20 calendar days after the certification holder received the order. With the request for reconsideration, the certification holder may submit a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 3. **Decertification due to maltreatment.** If the commissioner decertifies a center pursuant to subdivision 1, paragraph (a), clause (1), based on a determination that the center was responsible for maltreatment, and if the center requests reconsideration of the decertification according to subdivision 2, paragraph (a), and appeals the maltreatment

determination under section 626.556, subdivision 10i, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

Subd. 4. **Decertification due to revocation of child care assistance.** If the commissioner decertifies a center that had payments revoked pursuant to chapter 119B, and if the center appeals the revocation of the center's authorization to receive child care assistance payments, the final decertification determination is stayed until the appeal of the center's authorization under chapter 119B is resolved. If the center also requests reconsideration of the decertification, the center must do so according to subdivision 2, paragraph (a). The final decision on reconsideration is stayed until the appeal of the center's authorization under chapter 119B is resolved.

EFFECTIVE DATE. Subdivisions 1 to 3 are effective September 30, 2019. Subdivision 4 is effective February 26, 2021.

Sec. 90. Minnesota Statutes 2018, section 245H.10, subdivision 1, is amended to read:

Subdivision 1. ~~**Documentation**~~ **Individuals to be studied.** (a) The applicant or certification holder must submit ~~and maintain documentation of~~ a completed background study for~~:~~ each child care background study subject as defined in section 245C.02, subdivision 6a.

~~(1) each person applying for the certification;~~

~~(2) each person identified as a center operator or program operator as defined in section 245H.01, subdivision 3;~~

~~(3) each current or prospective staff person or contractor of the certified center who will have direct contact with a child served by the center;~~

~~(4) each volunteer who has direct contact with a child served by the center if the contact is not under the continuous, direct supervision by an individual listed in clause (1), (2), or (3); and~~

~~(5) each managerial staff person of the certification holder with oversight and supervision of the certified center.~~

(b) To be accepted for certification, a background study on every individual ~~in paragraph (a), clause (1),~~ applying for certification must be completed under chapter 245C and result in a not disqualified determination under section 245C.14 or a disqualification that was set aside under section 245C.22.

Sec. 91. Minnesota Statutes 2018, section 245H.11, is amended to read:

245H.11 REPORTING.

(a) The certification holder must comply and must have written policies for staff to comply with the reporting requirements for abuse and neglect specified in section 626.556. A person mandated to report physical or sexual child abuse or neglect occurring within a certified center shall report the information to the commissioner.

(b) The certification holder must inform the commissioner within 24 hours of:

(1) the death of a child in the program; and

(2) any injury to a child in the program that required treatment by a physician.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 92. Minnesota Statutes 2018, section 245H.13, subdivision 5, is amended to read:

Subd. 5. **Building and physical premises; free of hazards.** (a) ~~The certified center must document compliance with the State Fire Code by providing~~ To be accepted for certification, the applicant must demonstrate compliance with the State Fire Code, section 299F.011, by either:

(1) providing documentation of a fire marshal inspection completed within the previous three years by a state fire marshal or a local fire code inspector trained by the state fire marshal~~.~~; or

(2) complying with the fire marshal inspection requirements according to section 245A.151.

(b) The certified center must designate a primary indoor and outdoor space used for child care on a facility site floor plan.

(c) The certified center must ensure the areas used by a child are clean and in good repair, with structurally sound and functional furniture and equipment that is appropriate to the age and size of a child who uses the area.

(d) The certified center must ensure hazardous items including but not limited to sharp objects, medicines, cleaning supplies, poisonous plants, and chemicals are out of reach of a child.

(e) The certified center must safely handle and dispose of bodily fluids and other potentially infectious fluids by using gloves, disinfecting surfaces that come in contact with

potentially infectious bodily fluids, and disposing of bodily fluid in a securely sealed plastic bag.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 93. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 7. **Risk reduction plan.** (a) The certified center must develop a risk reduction plan that identifies risks to children served by the child care center. The assessment of risk must include risks presented by (1) the physical plant where the certified services are provided, including electrical hazards; and (2) the environment, including the proximity to busy roads and bodies of water.

(b) The certification holder must establish policies and procedures to minimize identified risks. After any change to the risk reduction plan, the certification holder must inform staff of the change in the risk reduction plan and document that staff were informed of the change.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 94. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 8. **Required policies.** A certified center must have written policies for health and safety items in subdivisions 1 to 6.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 95. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers use positive behavior guidance and do not subject children to:

(1) corporal punishment, including but not limited to rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

(2) humiliation;

(3) abusive language;

(4) the use of mechanical restraints, including tying;

(5) the use of physical restraints other than to physically hold a child when containment is necessary to protect a child or others from harm; or

(6) the withholding or forcing of food and other basic needs.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 96. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 10. **Supervision.** Staff must supervise each child at all times. Staff are responsible for the ongoing activity of each child, appropriate visual or auditory awareness, physical proximity, and knowledge of activity requirements and each child's needs. Staff must intervene when necessary to ensure a child's safety. In determining the appropriate level of supervision of a child, staff must consider: (1) the age of a child; (2) individual differences and abilities; (3) indoor and outdoor layout of the child care program; and (4) environmental circumstances, hazards, and risks.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 97. Minnesota Statutes 2018, section 245H.14, subdivision 1, is amended to read:

Subdivision 1. **First aid and cardiopulmonary resuscitation.** ~~At least one designated staff person who completed pediatric first aid training and pediatric cardiopulmonary resuscitation (CPR) training must be present at all times at the program, during field trips, and when transporting a child. The designated staff person must repeat pediatric first aid training and pediatric CPR training at least once every two years.~~

(a) Before having unsupervised direct contact with a child, but within the first 90 days of employment for the director and all staff persons, and within 90 days after the first date of direct contact with a child for substitutes and unsupervised volunteers, each person must successfully complete pediatric first aid and pediatric cardiopulmonary resuscitation (CPR) training, unless the training has been completed within the previous two calendar years. Staff must complete the pediatric first aid and pediatric CPR training at least every other calendar year and the center must document the training in the staff person's personnel record.

(b) Training completed under this subdivision may be used to meet the in-service training requirements under subdivision 6.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 98. Minnesota Statutes 2018, section 245H.14, subdivision 2, is amended to read:

Subd. 2. **Sudden unexpected infant death.** A certified center that cares for an infant who is younger than one year of age must ensure that the director, all staff persons, including substitutes, unsupervised volunteers, and any other volunteers receive training according to section 245A.1435 on reducing the risk of sudden unexpected infant death before assisting in the care of an infant.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 99. Minnesota Statutes 2018, section 245H.14, subdivision 3, is amended to read:

Subd. 3. **Abusive head trauma.** A certified center that cares for a child ~~through four years of age~~ under school age must ensure that the director and all staff persons ~~and volunteers~~, including substitutes and unsupervised volunteers, receive training on abusive head trauma ~~from shaking infants and young children~~ before assisting in the care of a child ~~through four years of age~~ under school age.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 100. Minnesota Statutes 2018, section 245H.14, subdivision 4, is amended to read:

Subd. 4. **Child development.** The certified center must ensure ~~each staff person completes at least two hours of~~ that the director and all staff persons complete child development and learning training within ~~14~~ 90 days of employment and ~~annually~~ every second calendar year thereafter. Substitutes and unsupervised volunteers must complete child development and learning training within 90 days after the first date of direct contact with a child and every second calendar year thereafter. The director and staff persons not including substitutes must complete at least two hours of training on child development. The training for substitutes and unsupervised volunteers is not required to be of a minimum length. For purposes of this subdivision, "child development and learning training" means how a child develops physically, cognitively, emotionally, and socially and learns as part of the child's family, culture, and community.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 101. Minnesota Statutes 2018, section 245H.14, subdivision 5, is amended to read:

Subd. 5. **Orientation.** The certified center must ensure ~~each staff person is~~ the director and all staff persons, substitutes, and unsupervised volunteers are trained at orientation on health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15. The

certified center must provide ~~staff with an~~ orientation within 14 days ~~of employment~~ after the first date of direct contact with a child. Before the completion of orientation, ~~a staff person~~ these individuals must be supervised while providing direct care to a child.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 102. Minnesota Statutes 2018, section 245H.14, subdivision 6, is amended to read:

Subd. 6. **In service.** (a) The certified center must ensure ~~each~~ that the director and all staff ~~person is~~ persons, including substitutes and unsupervised volunteers, are trained at least ~~annually~~ once each calendar year on health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15.

(b) The director and each staff person, not including substitutes, must ~~annually~~ complete at least six hours of training each calendar year. Training required under paragraph (a) may be used toward the hourly training requirements of this subdivision.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 103. Minnesota Statutes 2018, section 245H.15, subdivision 1, is amended to read:

Subdivision 1. **Written emergency plan.** (a) A certified center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of children, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to children. The plan must be written on a form developed by the commissioner and reviewed and updated at least once each calendar year. The annual review of the emergency plan must be documented.

(b) The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the relocation and reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; ~~and~~

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities.; and

(8) accommodations for infants and toddlers.

(c) The certification holder must have an emergency plan available for review upon request by the child's parent or legal guardian.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 104. Minnesota Statutes 2018, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) On July 1, 2018, or upon federal approval, whichever is later, a licensed professional in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2.

(c) On July 1, 2018, or upon federal approval, whichever is later, a county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and ~~4~~ 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, clause (7).

(d) On July 1, 2018, or upon federal approval, whichever is later, a recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

(e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

Sec. 105. Minnesota Statutes 2018, section 254B.05, subdivision 1b, is amended to read:

Subd. 1b. **Additional vendor requirements.** Vendors must comply with the following duties:

(1) maintain a provider agreement with the department;

(2) continually comply with the standards in the agreement;

(3) participate in the Drug Alcohol Normative Evaluation System;

(4) submit an annual financial statement which reports functional expenses of chemical dependency treatment costs in a form approved by the commissioner;

(5) report information about the vendor's current capacity in a manner prescribed by the commissioner; and

(6) maintain adequate and appropriate insurance coverage necessary to provide chemical dependency treatment services, and at a minimum:

(i) employee dishonesty in the amount of $10,000 if the vendor has or had custody or control of money or property belonging to clients; and

(ii) bodily injury and property damage in the amount of $2,000,000 for each occurrence, except that a county or a county joint powers entity who is otherwise an eligible vendor shall be subject to the limits on liability under section 466.04.

Sec. 106. Minnesota Statutes 2018, section 256.046, subdivision 1, is amended to read:

Subdivision 1. **Hearing authority.** A local agency must initiate an administrative fraud disqualification hearing for individuals~~, including child care providers caring for children receiving child care assistance,~~ accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, child care assistance programs, general assistance, family general assistance program formerly codified in section 256D.05, subdivision 1, clause (15), Minnesota supplemental aid, food stamp programs, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare except for children through age 18. The Department of Human Services, in lieu of a local agency, may initiate an administrative fraud disqualification hearing when the state agency is directly responsible for administration or investigation of the program for which benefits were wrongfully obtained. The hearing

is subject to the requirements of ~~section~~ sections 256.045 and 256.0451 and the requirements in Code of Federal Regulations, title 7, section 273.16.

Sec. 107. Minnesota Statutes 2018, section 256.046, is amended by adding a subdivision to read:

Subd. 3. **Administrative disqualification of child care providers caring for children receiving child care assistance.** (a) The department or local agency shall pursue an administrative disqualification, if the child care provider is accused of committing an intentional program violation, in lieu of a criminal action when it has not been pursued. Intentional program violations include intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E. Intent may be proven by demonstrating a pattern of conduct that violates program rules under chapters 119B and 245E.

(b) To initiate an administrative disqualification, a local agency or the commissioner must mail written notice by certified mail to the provider against whom the action is being taken. Unless otherwise specified under chapter 119B or 245E or Minnesota Rules, chapter 3400, a local agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date. The notice shall state (1) the factual basis for the agency's determination, (2) the action the agency intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known, and (4) the provider's right to appeal the agency's proposed action.

(c) The provider may appeal an administrative disqualification by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must be received by the Appeals Division no later than 30 days after the date a local agency or the commissioner mails the notice.

(d) The provider's appeal request must contain the following:

(1) each disputed item, the reason for the dispute, and, if applicable, an estimate of the dollar amount involved for each disputed item;

(2) the computation the provider believes to be correct, if applicable;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

(e) On appeal, the issuing agency bears the burden of proof to demonstrate by a preponderance of the evidence that the provider committed an intentional program violation.

(f) The hearing is subject to the requirements of sections 256.045 and 256.0451. The human services judge may combine a fair hearing and administrative disqualification hearing into a single hearing if the factual issues arise out of the same or related circumstances and the provider receives prior notice that the hearings will be combined.

(g) A provider found to have committed an intentional program violation and is administratively disqualified shall be disqualified, for a period of three years for the first offense and permanently for any subsequent offense, from receiving any payments from any child care program under chapter 119B.

(h) Unless a timely and proper appeal made under this section is received by the department, the administrative determination of the department is final and binding.

Sec. 108. Minnesota Statutes 2018, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or vouchers produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 109. Minnesota Statutes 2018, section 256.98, subdivision 8, is amended to read:

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support program, the general assistance program, housing support under chapter 256I, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp or food support program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of one year and two years for the first and second offenses, respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification must be for a period of ~~one year~~ three years for the first offense ~~and two years for the second offense~~. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults without children and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The

sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

Sec. 110. Minnesota Statutes 2018, section 256.983, is amended by adding a subdivision to read:

Subd. 5. **Child care providers; financial misconduct.** (a) A county or tribal agency may conduct investigations of financial misconduct by child care providers as described in chapter 245E. Prior to opening an investigation, a county or tribal agency must contact the commissioner to determine whether an investigation under this chapter may compromise an ongoing investigation.

(b) If, upon investigation, a preponderance of evidence shows a provider committed an intentional program violation, intentionally gave the county or tribe materially false information on the provider's billing forms, provided false attendance records to a county, tribe, or the commissioner, or committed financial misconduct as described in section 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies. The county must send notice in accordance with the requirements of section 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment suspension shall remain in effect until: (1) the commissioner, county, or a law enforcement authority determines that there is insufficient evidence warranting the action and a county, tribe, or the commissioner does not pursue an additional administrative remedy under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

(c) For the purposes of this section, an intentional program violation includes intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E.

(d) A provider has the right to administrative review under section 119B.161 if: (1) payment is suspended under chapter 245E; or (2) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (2).

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 111. Minnesota Statutes 2018, section 256B.02, subdivision 7, is amended to read:

Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, ambulatory surgical center services, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in section 145A.02, subdivision 18; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided; and such other ~~medical~~ services or supplies provided or prescribed by persons authorized by state law to give such services and supplies. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

(b) "Vendor of medical care" also includes any person who is credentialed as a health professional under standards set by the governing body of a federally recognized Indian tribe authorized under an agreement with the federal government according to United States Code, title 25, section 450f, to provide health services to its members, and who through a tribal facility provides covered services to American Indian people within a contract health service delivery area of a Minnesota reservation, as defined under Code of Federal Regulations, title 42, section 36.22.

(c) A federally recognized Indian tribe that intends to implement standards for credentialing health professionals must submit the standards to the commissioner of human services, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The commissioner shall maintain a copy of the standards and supporting evidence, and shall use those standards to enroll tribal-approved health professionals as medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean persons or entities that meet the definition in United States Code, title 25, section 450b.

Sec. 112. Minnesota Statutes 2018, 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 is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, 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. The commissioner may exempt a rehabilitation agency from termination or denial that would otherwise be required under this paragraph, if the agency:

(1) is unable to retain Medicare certification and enrollment solely due to a lack of billing to the Medicare program;

(2) meets all other applicable Medicare certification requirements based on an on-site review completed by the commissioner of health; and

(3) serves primarily a pediatric population.

(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 notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), 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. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety 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 surety 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 surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a 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 surety 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 surety 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. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

Sec. 113. Minnesota Statutes 2018, section 256B.064, subdivision 1b, is amended to read:

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to a vendor and suspending or terminating participation in the program, or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under this section, the commissioner shall consider the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the vendor. The commissioner shall suspend a vendor's participation in the program for a minimum of five years if the

vendor is convicted of a crime, received a stay of adjudication, or entered a court-ordered diversion program for an offense related to a provision of a health service under medical assistance or health care fraud. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

Sec. 114. Minnesota Statutes 2018, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(4) identify the types of claims to which the withholding applies; and

(5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the vendor, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon conviction for a crime related to the provision, management, or administration of a health service under medical assistance, a payment held pursuant to this section by the commissioner or a managed care organization that contracts with the commissioner under section 256B.035 is forfeited to the commissioner or managed care organization, regardless of the amount charged in the criminal complaint or the amount of criminal restitution ordered.

(d) The commissioner shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program.

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

(f) The commissioner may order a vendor to forfeit a fine for failure to fully document services according to standards in this chapter and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to $5,000, whichever is less. If the commissioner determines that a vendor repeatedly violated this chapter or Minnesota Rules, chapter 9505, related to the provision of services to program recipients and the submission of claims for payment, the commissioner may order a vendor to forfeit a fine based on the nature, severity, and chronicity of the violations, in an amount of up to $5,000 or 20 percent of the value of the claims, whichever is greater.

(g) The vendor shall pay the fine assessed on or before the payment date specified. If the vendor fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

Sec. 115. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision to read:

Subd. 3. **Vendor mandates on prohibited payments.** (a) The commissioner shall maintain and publish a list of each excluded individual and entity that was convicted of a crime related to the provision, management, or administration of a medical assistance health service, or suspended or terminated under subdivision 2. Medical assistance payments cannot

be made by a vendor for items or services furnished either directly or indirectly by an excluded individual or entity, or at the direction of excluded individuals or entities.

(b) The vendor must check the exclusion list on a monthly basis and document the date and time the exclusion list was checked and the name and title of the person who checked the exclusion list. The vendor must immediately terminate payments to an individual or entity on the exclusion list.

(c) A vendor's requirement to check the exclusion list and to terminate payments to individuals or entities on the exclusion list applies to each individual or entity on the exclusion list, even if the named individual or entity is not responsible for direct patient care or direct submission of a claim to medical assistance.

(d) A vendor that pays medical assistance program funds to an individual or entity on the exclusion list must refund any payment related to either items or services rendered by an individual or entity on the exclusion list from the date the individual or entity is first paid or the date the individual or entity is placed on the exclusion list, whichever is later, and a vendor may be subject to:

(1) sanctions under subdivision 2;

(2) a civil monetary penalty of up to $25,000 for each determination by the department that the vendor employed or contracted with an individual or entity on the exclusion list; and

(3) other fines or penalties allowed by law.

Sec. 116. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision to read:

Subd. 4. **Notice.** (a) The notice required under subdivision 2 shall be served by certified mail at the address submitted to the department by the vendor. Service is complete upon mailing. The commissioner shall place an affidavit of the certified mailing in the vendor's file as an indication of the address and the date of mailing.

(b) The department shall give notice in writing to a recipient placed in the Minnesota restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200. The notice shall be sent by first class mail to the recipient's current address on file with the department. A recipient placed in the Minnesota restricted recipient program may contest the placement by submitting a written request for a hearing to the department within 90 days of the notice being mailed.

Sec. 117. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision to read:

Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report is immune from any civil or criminal liability that might otherwise arise from reporting or participating in the investigation. Nothing in this subdivision affects a vendor's responsibility for an overpayment established under this subdivision.

(b) A person employed by a lead investigative agency who is conducting or supervising an investigation or enforcing the law according to the applicable law or rule is immune from any civil or criminal liability that might otherwise arise from the person's actions, if the person is acting in good faith and exercising due care.

(c) For purposes of this subdivision, "person" includes a natural person or any form of a business or legal entity.

(d) After an investigation is complete, the reporter's name must be kept confidential. The subject of the report may compel disclosure of the reporter's name only with the consent of the reporter or upon a written finding by a district court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that when the identity of the reporter is relevant to a criminal prosecution the district court shall conduct an in-camera review before determining whether to order disclosure of the reporter's identity.

Sec. 118. **[256B.0646] MINNESOTA RESTRICTED RECIPIENT PROGRAM; PERSONAL CARE ASSISTANCE SERVICES.**

(a) When a recipient's use of personal care assistance services or community first services and supports under section 256B.85 results in abusive or fraudulent billing, the commissioner may place a recipient in the Minnesota restricted recipient program under Minnesota Rules, part 9505.2165. A recipient placed in the Minnesota restricted recipient program under this section must: (1) use a designated traditional personal care assistance provider agency; and (2) obtain a new assessment under section 256B.0911, including consultation with a registered or public health nurse on the long-term care consultation team pursuant to section 256B.0911, subdivision 3, paragraph (b), clause (2).

(b) A recipient must comply with additional conditions for the use of personal care assistance services or community first services and supports if the commissioner determines it is necessary to prevent future misuse of personal care assistance services or abusive or fraudulent billing. Additional conditions may include but are not limited to restricting service

authorizations for a duration of no more than one month and requiring a qualified professional to monitor and report services on a monthly basis.

(c) A recipient placed in the Minnesota restricted recipient program under this section may appeal the placement according to section 256.045.

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

Sec. 119. Minnesota Statutes 2018, section 256B.0651, subdivision 17, is amended to read:

Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days prior to terminating services to a recipient, if the termination results from provider sanctions under section 256B.064, such as a payment withhold, a suspension of participation, or a termination of participation. If a home care provider determines it is unable to continue providing services to a recipient, the provider must notify the recipient, the recipient's responsible party, and the commissioner 30 days prior to terminating services to the recipient because of an action under section 256B.064, and must assist the commissioner and lead agency in supporting the recipient in transitioning to another home care provider of the recipient's choice.

(b) In the event of a payment withhold from a home care provider, a suspension of participation, or a termination of participation of a home care provider under section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all recipients with active service agreements with the provider. At the commissioner's request, the lead agencies must contact recipients to ensure that the recipients are continuing to receive needed care, and that the recipients have been given free choice of provider if they transfer to another home care provider. In addition, the commissioner or the commissioner's delegate may directly notify recipients who receive care from the provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that notification is necessary to protect the welfare of the recipients. For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care organizations.

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

Sec. 120. Minnesota Statutes 2018, section 256B.0659, subdivision 12, is amended to read:

Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal care assistance services for a recipient must be documented daily by each personal care assistant, 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 basis to the provider and kept in the recipient's health record.

(b) The activity documentation must correspond to the personal care assistance care plan and be reviewed by the qualified professional.

(c) The personal care assistant time sheet must be on a form approved by the commissioner documenting time the personal care assistant provides services in the home. The following criteria must be included in the time sheet:

(1) full name of personal care assistant and individual provider number;

(2) provider name and telephone numbers;

(3) full name of recipient and either the recipient's medical assistance identification number or date of birth;

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

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

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

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

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

Sec. 121. Minnesota Statutes 2018, section 256B.27, subdivision 3, is amended to read:

Subd. 3. **Access to medical records.** The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false

in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or (b) the medical care was medically necessary. ~~The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records.~~ When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the vendor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. The department shall document in writing the need for immediate access to records related to a specific investigation. Denying the commissioner access to records is cause for the vendor's immediate suspension of payment or termination according to section 256B.064. The determination of provision of services not medically necessary shall be made by the commissioner. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

Sec. 122. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 11. **Home and community-based service billing requirements.** (a) A home and community-based service is eligible for reimbursement if:

(1) the service is provided according to a federally approved waiver plan as authorized under sections 256B.0913, 256B.0915, 256B.092, and 256B.49;

(2) if applicable, the service is provided on days and times during the days and hours of operation specified on any license required under chapter 245A or 245D; and

(3) the provider complies with subdivisions 12 to 15, if applicable.

(b) The provider must maintain documentation that, upon employment and annually thereafter, staff providing a service have attested to reviewing and understanding the following statement: "It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49."

(c) The department may recover payment according to section 256B.064 and Minnesota Rules, parts 9505.2160 to 9505.2245, for a service that does not satisfy this subdivision.

Sec. 123. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 12. **Home and community-based service documentation requirements.** (a) Documentation may be collected and maintained electronically or in paper form by providers and must be produced upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

(2) the day, month, and year when the service was provided;

(3) the start and stop times with a.m. and p.m. designations, except for case management services as defined under sections 256B.0913, subdivision 7; 256B.0915, subdivision 1a; 256B.092, subdivision 1a; and 256B.49, subdivision 13;

(4) the service name or description of the service provided; and

(5) the name, signature, and title, if any, of the provider of service. If the service is provided by multiple staff members, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

(d) If the service is reimbursed at a daily rate or does not meet the requirements in paragraph (c), each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

(2) the day, month, and year when the service was provided;

(3) the service name or description of the service provided; and

(4) the name, signature, and title, if any, of the person providing the service. If the service is provided by multiple staff, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

Sec. 124. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 13. **Waiver transportation documentation and billing requirements.** (a) A waiver transportation service must be a waiver transportation service that: (1) is not covered

by medical transportation under the Medicaid state plan; and (2) is not included as a component of another waiver service.

(b) In addition to the documentation requirements in subdivision 12, a waiver transportation service provider must maintain:

(1) odometer and other records pursuant to section 256B.0625, subdivision 17b, paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver for a waiver transportation service that is billed directly by the mile. A common carrier as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or a publicly operated transit system provider are exempt from this clause; and

(2) documentation demonstrating that a vehicle and a driver meet the standards determined by the Department of Human Services on vehicle and driver qualifications in section 256B.0625, subdivision 17, paragraph (c).

Sec. 125. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 14. **Equipment and supply documentation requirements.** (a) In addition to the requirements in subdivision 12, an equipment and supply services provider must for each documentation of the provision of a service include:

(1) the recipient's assessed need for the equipment or supply;

(2) the reason the equipment or supply is not covered by the Medicaid state plan;

(3) the type and brand name of the equipment or supply delivered to or purchased by the recipient, including whether the equipment or supply was rented or purchased;

(4) the quantity of the equipment or supply delivered or purchased; and

(5) the cost of the equipment or supply if the amount paid for the service depends on the cost.

(b) A provider must maintain a copy of the shipping invoice or a delivery service tracking log or other documentation showing the date of delivery that proves the equipment or supply was delivered to the recipient or a receipt if the equipment or supply was purchased by the recipient.

Sec. 126. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 15. **Adult day service documentation and billing requirements.** (a) In addition to the requirements in subdivision 12, a provider of adult day services as defined in section 245A.02, subdivision 2a, and licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, must maintain documentation of:

(1) a needs assessment and current plan of care according to section 245A.143, subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, for each recipient, if applicable;

(2) attendance records as specified under section 245A.14, subdivision 14, paragraph (c), including the date of attendance with the day, month, and year; and the pickup and drop-off time in hours and minutes with a.m. and p.m. designations;

(3) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710, subparts 1, items E and H; 3; 4; and 6, if applicable;

(4) the name and qualification of each registered physical therapist, registered nurse, and registered dietitian who provides services to the adult day services or nonresidential program; and

(5) the location where the service was provided. If the location is an alternate location from the usual place of service, the documentation must include the address, or a description if the address is not available, of both the origin site and destination site; the length of time at the alternate location with a.m. and p.m. designations; and a list of participants who went to the alternate location.

(b) A provider must not exceed the provider's licensed capacity. If a provider exceeds the provider's licensed capacity, the department must recover all Minnesota health care programs payments from the date the provider exceeded licensed capacity.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 127. **EVALUATION OF GRANT PROGRAMS; PROVEN-EFFECTIVE PRACTICES.**

(a) The commissioner of management and budget shall consult with the commissioner of human services to establish a plan to review the services delivered under grant programs administered by the commissioner of human services to determine whether the grant programs prioritize proven-effective or promising practices.

(b) In accordance with the plan established in paragraph (a), the commissioner of management and budget, in consultation with the commissioner of human services, shall identify services to evaluate using an experimental or quasi-experimental design to provide information needed to modify or develop grant programs to promote proven-effective practices to improve the intended outcomes of the grant program.

(c) The commissioner of management and budget, in consultation with the commissioner of human services, shall develop reports for the legislature and other stakeholders to provide information on incorporating proven-effective practices in program and budget decisions. The commissioner of management and budget, under Minnesota Statutes, section 15.08, may obtain additional relevant data to support the evaluation activities under this section.

(d) For purposes of this section, the following terms have the meanings given:

(1) "proven-effective practice" means a service or practice that offers a high level of research on effectiveness for at least one outcome of interest, as determined through multiple evaluations outside of Minnesota or one or more local evaluation in Minnesota. The research on effectiveness used to determine whether a service is proven-effective must use rigorously implemented experimental or quasi-experimental designs; and

(2) "promising practices" means a service or practice that is supported by research demonstrating effectiveness for at least one outcome of interest, and includes a single evaluation that is not contradicted by other studies, but does not meet the full criteria for the proven-effective designation. The research on effectiveness used to determine whether a service is a promising practice must use rigorously implemented experimental or quasi-experimental designs.

Sec. 128. **DIRECTION TO COMMISSIONER; CORRECTION ORDER ENFORCEMENT REVIEW.**

By January 1, 2020, the commissioner of human services shall develop and implement a process to review licensing inspection results provided under Minnesota Statutes, section 245A.16, subdivision 1, paragraph (h), clause (1), by county to identify trends in correction order enforcement. The commissioner shall develop guidance and training as needed to address any imbalance or inaccuracy in correction order enforcement. The commissioner shall include the results in the annual report on child care under Minnesota Statutes, section 245A.153, provided that the results are limited to summary data as defined in Minnesota Statutes, section 13.02, subdivision 19.

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

Sec. 129. **DIRECTION TO COMMISSIONER; RESPONSIBILITY FOR FRAUD INVESTIGATIONS IN PUBLIC PROGRAMS.**

No later than January 15, 2020, the commissioner of human services, in consultation with counties, shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services on recommendations for legislation that identifies and clarifies the responsibilities of the department and counties for fraud investigations in public programs administered by the commissioner.

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

Sec. 130. **DIRECTION TO COMMISSIONER; SELF-EMPLOYMENT INCOME IN PUBLIC ASSISTANCE PROGRAMS.**

No later than January 15, 2020, the commissioner of human services, in consultation with counties and other relevant stakeholders, shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services with recommendations for legislation on how to count self-employment income for purposes of determining eligibility for and maintaining the integrity of public assistance programs.

Sec. 131. **DIRECTION TO COMMISSIONER; SUBSTANCE USE DISORDER COUNTY STAFF QUALIFICATIONS.**

The commissioner of human services shall, in consultation with county agencies, identify specific training, education, and experience requirements that would qualify individuals employed by a county who are not alcohol and drug counselors to perform comprehensive assessments and treatment coordination. The commissioner shall provide a list of resources available to meet the necessary training and education requirements. By December 1, 2019, the commissioner shall provide a progress update to the chairs and ranking minority members of the legislative committees with jurisdiction over substance use disorder services and provide recommendations on any statutory changes needed to implement this section.

Sec. 132. **FAMILY CHILD CARE TASK FORCE.**

Subdivision 1. **Membership.** (a) The Family Child Care Task Force shall consist of 25 members, appointed as follows:

(1) two members representing family child care providers from greater Minnesota, including one appointed by the speaker of the house and one appointed by the senate majority leader;

(2) two members representing family care providers from the metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2, including one appointed by the speaker of the house and one appointed by the senate majority leader;

(3) one member appointed by the Minnesota Association of Child Care Professionals;

(4) one member appointed by the Minnesota Child Care Provider Information Network;

(5) two members from the house of representatives, including one appointed by the speaker of the house and one appointed by the minority leader;

(6) two members from the senate, including one appointed by the senate majority leader and one appointed by the senate minority leader;

(7) the commissioner of human services or designee;

(8) two members representing Department of Human Services-recognized family child care associations from greater Minnesota, appointed by the commissioner of human services;

(9) two members appointed by the Association of Minnesota Child Care Licensors, including one from greater Minnesota and one from the metropolitan area, as defined in Minnesota Statutes, section 473.121, subdivision 2;

(10) four parents of children enrolled in family child care programs, appointed by the commissioner of human services;

(11) one member appointed by the Greater Minnesota Partnership;

(12) one member appointed by the Minnesota Chamber of Commerce;

(13) one member appointed by Child Care Aware of Minnesota;

(14) one member appointed by the Minnesota Initiative Foundation;

(15) one member appointed by Minnesota's Children's Cabinet; and

(16) one member appointed by First Children's Finance.

(b) Appointments to the task force must be made by July 15, 2019.

Subd. 2. **Compensation.** Public members of the task force may be compensated as provided by Minnesota Statutes, section 15.059, subdivision 3.

Subd. 3. **Duties.** The task force shall:

(1) identify difficulties that providers face regarding licensing and inspection, including specific licensing requirements that have led to the closure of family child care programs, by reviewing previous survey results and conducting follow-up surveys, if necessary;

(2) propose regulatory reforms to improve licensing efficiency, including discussion of criteria that would qualify a provider for an abbreviated licensing review based on statistically significant key indicators that predict full compliance with all applicable rules and statutes, and discussion of the development of a risk-based, data driven, tiered violation system with corresponding enforcement mechanisms that are appropriate to the risk presented by a violation;

(3) review existing variance authority delegated to counties and recommend changes, if needed;

(4) recommend business development and technical assistance resources to promote provider recruitment and retention, including the potential need for mentors, a family child care provider network, or shared services;

(5) develop recommendations for alternative child care delivery systems that could be more financially viable in smaller communities with unmet child care capacity needs in greater Minnesota, which could include new licensure models for large group family child care or small capacity child care centers;

(6) review Parent Aware program participation and identify obstacles and suggested improvements;

(7) review how trainings for licensed family child care providers are offered, provided, coordinated, and approved, and make a recommendation on the establishment of a family child care continuing education training committee, to advise on compliance with federal and state training requirements; and

(8) consider methods to improve access to and understanding of the rules and statutes governing family child care providers.

Subd. 4. **Officers; meetings.** (a) The task force shall be cochaired by the task force member from the majority party of the house of representatives and the task force member from the majority party of the senate, and may elect other officers as necessary.

(b) The commissioner of human services shall convene the first meeting by August 15, 2019.

(c) The cochairs shall alternate possession of the gavel between meetings.

(d) Each meeting shall be moderated by a neutral third-party facilitator.

(e) The agenda for each meeting shall be determined by the cochairs, the commissioner of human services or designee, and the facilitator.

(d) Meetings of the task force are subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. **Report required.** The task force shall submit an interim written report by March 1, 2020, and a final written report by February 1, 2021, to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over child care. The reports shall explain the task force's findings and recommendations relating to each of the duties under subdivision 3, and include any draft legislation necessary to implement the recommendations.

Subd. 6. **Expiration.** The task force expires upon submission of the final report in subdivision 5 or February 1, 2021, whichever is later.

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

Sec. 133. **INSTRUCTION TO COMMISSIONER; REVIEW OF CHILD CARE LICENSING AND BACKGROUND STUDY PROVISIONS.**

The commissioner of human services shall review existing statutes and rules relating to child care licensing and background study requirements and propose legislation for the 2020 legislative session that eliminates unnecessary and duplicative record keeping or documentation requirements for child care providers. The commissioner shall also establish a process for child care providers to electronically submit requested information to the commissioner.

Sec. 134. **REPEALER.**

(a) Minnesota Rules, parts 9502.0425, subparts 4, 16, and 17; and 9503.0155, subpart 8, are repealed.

(b) Minnesota Statutes 2018, sections 119B.125, subdivision 8; and 245H.10, subdivision 2, are repealed.

(c) Minnesota Rules, part 2960.3030, subpart 3, is repealed.

EFFECTIVE DATE. Paragraphs (a) and (b) are effective September 30, 2019. Paragraph (c) is effective October 1, 2019.

ARTICLE 3
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2018, section 246.54, is amended by adding a subdivision to read:

Subd. 3. **Administrative review of county liability for cost of care.** (a) The county of financial responsibility may submit a written request for administrative review by the commissioner of the county's payment of the cost of care when a delay in discharge of a client from a regional treatment center, state-operated community-based behavioral health hospital, or other state-operated facility results from the following actions by the facility:

(1) the facility did not provide notice to the county that the facility has determined that it is clinically appropriate for a client to be discharged;

(2) the notice to the county that the facility has determined that it is clinically appropriate for a client to be discharged was communicated on a holiday or weekend;

(3) the required documentation or procedures for discharge were not completed in order for the discharge to occur in a timely manner; or

(4) the facility disagrees with the county's discharge plan.

(b) The county of financial responsibility may not appeal the determination that it is clinically appropriate for a client to be discharged from a regional treatment center, state-operated community-based behavioral health hospital, or other state-operated facility.

(c) The commissioner must evaluate the request for administrative review and determine if the facility's actions listed in paragraph (a) caused undue delay in discharging the client. If the commissioner determines that the facility's actions listed in paragraph (a) caused undue delay in discharging the client, the county's liability must be reduced to the level of the cost of care for a client whose stay in a facility is determined to be clinically appropriate, effective on the date of the facility's action or failure to act that caused the delay. The commissioner's determination under this subdivision is final and not subject to appeal.

(d) If a county's liability is reduced pursuant to paragraph (c), a county's liability must return to the level of the cost of care for a client whose stay in a facility is determined to no longer be appropriate effective on the date the facility rectifies the action or failure to act that caused the delay under paragraph (a).

(e) Any difference in the county cost of care liability resulting from administrative review under this subdivision must not be billed to the client or applied to future reimbursement from the client's estate or relatives.

Sec. 2. Minnesota Statutes 2018, section 246B.10, is amended to read:

246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.

(a) The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided in the Minnesota sex offender program to a civilly committed sex offender who has legally settled in that county.

(b) A county's payment must be made from the county's own sources of revenue and payments must:

(1) equal ten percent of the cost of care, as determined by the commissioner, for each day or portion of a day that the civilly committed sex offender spends at the facility for individuals admitted to the Minnesota sex offender program before August 1, 2011; or

(2) equal 25 percent of the cost of care, as determined by the commissioner, for each day or portion of a day~~,~~ that the civilly committed sex offender:

(i) spends at the facility~~.~~ for individuals admitted to the Minnesota sex offender program on or after August 1, 2011; or

(ii) receives services within a program operated by the Minnesota sex offender program while on provisional discharge.

(c) The county is responsible for paying the state the remaining amount if payments received by the state under this chapter exceed:

(1) 90 percent of the cost of care for individuals admitted to the Minnesota sex offender program before August 1, 2011; or

(2) 75 percent of the cost of care~~, the county is responsible for paying the state the remaining amount~~ for individuals:

(i) admitted to the Minnesota sex offender program on or after August 1, 2011; or

(ii) receiving services within a program operated by the Minnesota sex offender program while on provisional discharge.

(d) The county is not entitled to reimbursement from the civilly committed sex offender, the civilly committed sex offender's estate, or from the civilly committed sex offender's relatives, except as provided in section 246B.07.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 3. **DIRECTION TO COMMISSIONER; REPORT REQUIRED; DISCHARGE DELAY REDUCTION.**

No later than January 1, 2023, the commissioner of human services must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services that provides an update on county and state efforts to reduce the number of days clients spend in state-operated facilities after discharge from the facility has been determined to be clinically appropriate. The report must also include information on the fiscal impact of clinically inappropriate stays in these facilities.

Sec. 4. **REPEALER.**

(a) Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

(b) Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10, is repealed.

ARTICLE 4
CONTINUING CARE FOR OLDER ADULTS

Section 1. Minnesota Statutes 2018, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

(a) "Attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.

(b) ~~"Buildings"~~ "Building" has the meaning given in ~~Minnesota Rules, part 9549.0020, subpart 7~~ section 256R.261, subdivision 4.

(c) "Capital assets" has the meaning given in section ~~256B.421, subdivision 16~~ 256R.02, subdivision 8.

(d) "Commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "Completion date" means the date on which clearance for the construction project is issued, or if a clearance for the construction project is not required, the date on which the construction project assets are available for facility use.

(f) "Construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "Construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space; and

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months.

(h) "Depreciation guidelines" ~~means the most recent publication of "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois, 60611~~ has the meaning given in section 256R.261, subdivision 11.

(i) "New licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

~~(j) "Project construction costs" means the cost of the following items that have a completion date within 12 months before or after the completion date of the project described in item (g), clause (1):~~

~~(1) facility capital asset additions;~~

~~(2) replacements;~~

~~(3) renovations;~~

~~(4) remodeling projects;~~

~~(5) construction site preparation costs;~~

~~(6) related soft costs; and~~

~~(7) the cost of new technology implemented as part of the construction project and depreciable equipment directly identified to the project, if the construction costs for clauses (1) to (6) exceed the threshold for additions and replacements stated in section 256B.431, subdivision 16. Technology and depreciable equipment shall be included in the project construction costs unless a written election is made by the facility, to not include it in the facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5. Debt incurred for purchase of technology and depreciable equipment shall be included as allowable debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C, unless the written election is to not include it. Any new technology and depreciable equipment included in the project construction costs that the facility elects not to include in its appraised value and allowable debt shall be treated as provided in section 256B.431, subdivision 17, paragraph (b). Written election under this paragraph must be included in the facility's request for the rate change related to the project, and this election may not be changed.~~

~~(k) "Technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.~~

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 2. Minnesota Statutes 2018, section 144A.071, subdivision 2, is amended to read:

Subd. 2. **Moratorium.** The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not allow medical assistance intake shall be deemed to be decertified for purposes of this section only.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds $1,000,000, unless:

(a) any construction costs exceeding $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, ground shifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met; or

~~(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, paragraph (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the Department of Health or documentation from a financial institution that financing arrangements for the construction project have been made; or~~

~~(6)~~ (5) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the ~~commissioner~~ commissioners of health and human services shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the ~~commissioner~~ commissioners and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the ~~commissioner~~ commissioners, the total project construction costs for the construction project shall be submitted to the ~~commissioner~~ commissioners. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not

recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is $1,000,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

Sec. 3. Minnesota Statutes 2018, section 144A.071, subdivision 3, is amended to read:

Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of new licensed and Medicare and Medicaid certified nursing home beds, using the criteria and process set forth in this subdivision.

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per thousand in a specified area using as a standard the beds per thousand people age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five year age groups, using data from the most recent census and

population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information. The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in subdivision 1a, paragraph (d). If, after the approved beds have been added, fewer than 50 percent of the beds in a facility are newly licensed, the operating payment rates previously

in effect shall remain. If, after the approved beds have been added, 50 percent or more of the beds in a facility are newly licensed, operating and external fixed payment rates shall be determined according to ~~Minnesota Rules, part 9549.0057, using the limits under sections 256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates must be determined according to section 256R.25~~ section 256R.21, subdivision 5. Property payment rates for facilities with beds added under this subdivision must be determined ~~in the same manner as rate determinations resulting from projects approved and completed under section 144A.073~~ under section 256R.26.

(e) The commissioner may:

(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

(2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section 256R.02, subdivision 43, to the prior licensee within 120 days after delicensure or decertification.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 4. Minnesota Statutes 2018, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify

the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434 or chapter 256R;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the

dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for the new nursing facilities shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256R.26. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256R.50;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation

of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256R.40;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood.

The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under chapter 256R and Minnesota Rules, parts 9549.0010 to 9549.0080; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 5. Minnesota Statutes 2018, section 144A.071, subdivision 4c, is amended to read:

Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(1) to license and certify an 80-bed city-owned facility in Nicollet County to be constructed on the site of a new city-owned hospital to replace an existing 85-bed facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility;

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073;

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias;

(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 per day shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434;

(5) to initiate a pilot program to license and certify up to 80 beds transferred from an existing county-owned nursing facility in Steele County relocated to the site of a new acute care facility as part of the county's Communities for a Lifetime comprehensive plan to create innovative responses to the aging of its population. Upon relocation to the new site, the

nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days; and

(6) to consolidate and relocate nursing facility beds to a new site in Goodhue County and to integrate these services with other community-based programs and services under a communities for a lifetime pilot program and comprehensive plan to create innovative responses to the aging of its population. Two nursing facilities, one for 84 beds and one for 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding the carryforward of the approval authority in section 144A.073, subdivision 11, the funding approved in April 2009 by the commissioner of health for a project in Goodhue County shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure rate adjustment under section 256R.40. The construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (vi):

(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) multiply the amount in item (iv) by 57.2 percent; and

(vi) divide the difference of the amount in item (iv) and the amount in item (v) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 6. Minnesota Statutes 2018, section 144A.071, subdivision 4d, is amended to read:

Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate an external fixed costs rate adjustment according to clauses (1) to (3):

(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section 256R.40, subdivision 5;

(2) the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and

(3) the payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the first day of the month of January or July, whichever date occurs first following both the completion of the construction upgrades in the consolidation plan and the complete closure of the facility or facilities designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

(b) For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):

(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;

(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;

(3) the estimated annual cost of elderly waiver recipients receiving support under housing support under chapter 256I;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;

(5) the annual loss of license surcharge payments on closed beds;

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 256R.40; and

(7) the savings from not paying external fixed costs payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming

95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

(e) To qualify for the external fixed costs payment rate adjustment under this subdivision, the closing facilities shall:

(1) submit an application for closure according to section 256R.40, subdivision 2; and

(2) follow the resident relocation provisions of section 144A.161.

(f) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under subdivision 3 for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

(g) Projects approved on or after March 1, 2020, are not subject to paragraph (a), clauses (2) and (3), and paragraph (c). The 65 percent projected net cost savings to the state calculated in paragraph (b) must be applied to the moratorium cost of the project and the remainder must be added to the moratorium funding under section 144A.073, subdivision 11.

(h) Consolidation project applications not approved by the commissioner prior to March 1, 2020, are subject to the moratorium process under section 144A.073, subdivision 2. Upon request by the applicant, the commissioner may extend this deadline to August 1, 2020, so long as the facilities, bed numbers, and counties specified in the original application are not altered. Proposals from facilities seeking approval for a consolidation project prior to March 1, 2020, must be received by the commissioner no later than January 1, 2020. This paragraph expires August 1, 2020.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 7. Minnesota Statutes 2018, section 144A.071, subdivision 5a, is amended to read:

Subd. 5a. **Cost estimate of a moratorium exception project.** ~~(a)~~ For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall

include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the property payment rate to be established upon completion of the project and total state annual long-term costs of each moratorium exception proposal. The property payment rate estimate shall be based upon the estimated costs and total building valuation to be used in the total property payment rate calculation under section 256R.26. For the purposes of determining the actual total property payment rate under section 256R.26 upon completion of the project, the final building valuation is the lesser of the limited depreciated replacement cost as determined under section 256R.26, subdivision 3, following a physical building appraisal or 105 percent of the estimated total building valuation from the moratorium application.

~~(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under Minnesota Rules, part 9549.0060, subpart 6.~~

~~The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.~~

EFFECTIVE DATE. This section is effective for projects approved by the commissioner of health on or after March 1, 2020.

Sec. 8. Minnesota Statutes 2018, section 144A.073, subdivision 3c, is amended to read:

Subd. 3c. ~~**Cost neutral** **Bed** **relocation** **threshold** **projects.** (a) Notwithstanding subdivision 3, the commissioner may at any time accept proposals, or amendments to proposals previously approved under this section, for relocations ~~that are cost neutral with respect to state costs as defined in section 144A.071, subdivision 5a~~ to existing licensed nursing facilities when costs are less than the maximum threshold limit determined under section 256R.267, paragraph (a). The commissioner, in consultation with the commissioner of human services, shall evaluate proposals according to subdivision 4a, clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. ~~The commissioner of human services shall determine the allowable payment rates of the facility receiving the beds in accordance with section 256R.50~~ The commissioner of human services shall determine the allowable payment rates of the facility receiving the beds in accordance with section 256R.21. No part of the source facility rates are transferred to the receiving facility. The commissioner shall approve or disapprove a project within 90 days.

(b) ~~For the purposes of paragraph (a), cost neutrality shall be measured over the first three 12-month periods of operation after completion of the project.~~ Bed relocation threshold projects seeking reimbursement for costs that exceed the moratorium limit or that result in a newly constructed or newly licensed building must apply to relocate beds as part of the competitive moratorium application and review process under subdivisions 2 and 3.

EFFECTIVE DATE. This section is effective for project proposals received by the commissioner of health after January 1, 2020, and approved by the commissioner on or after March 1, 2020.

Sec. 9. Minnesota Statutes 2018, section 144A.073, is amended by adding a subdivision to read:

Subd. 16. **Moratorium exception funding.** In fiscal year 2020, the commissioner may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed $1,250,000 plus any carryover of previous appropriations for this purpose.

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

Sec. 10. Minnesota Statutes 2018, section 256B.434, subdivision 1, is amended to read:

Subdivision 1. ~~**Alternative payment demonstration project established**~~ **Contractual agreements.** ~~The commissioner of human services shall establish a contractual alternative~~

~~payment demonstration project for paying for nursing facility services under the medical assistance program. A nursing facility may apply to be paid under the contractual alternative payment demonstration project instead of the cost-based payment system established under section 256B.431. A nursing facility~~ A nursing facility located in Minnesota electing to ~~use the alternative payment demonstration project~~ enroll as a medical assistance provider must enter into a contract with the commissioner. Payment rates and procedures ~~for facilities electing to use the alternative payment demonstration project~~ are determined and governed by this section and by the terms of the contract. The commissioner may negotiate different contract terms for different nursing facilities.

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

Sec. 11. Minnesota Statutes 2018, section 256B.434, subdivision 3, is amended to read:

Subd. 3. **Duration and termination of contracts.** ~~(a) Subject to available resources, the commissioner may begin to execute contracts with nursing facilities November 1, 1995.~~

~~(b)~~ (a) All contracts entered into under this section are for a term not to exceed four years. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable. ~~Notwithstanding section 16C.05, subdivision 2, paragraph (a), clause (5), the contract shall be renegotiated for additional terms of up to four years, unless either party provides written notice of termination.~~ The provisions of the contract shall be renegotiated at a minimum of every four years by the parties prior to the expiration date of the contract. The parties may voluntarily ~~renegotiate~~ amend the terms of the contract at any time by mutual agreement.

~~(c)~~ (b) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. ~~If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective the date the contract is terminated. The contract shall contain a provision governing the transition back to the cost-based reimbursement system established under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. A contract entered into under this section may be amended by mutual agreement of the parties.~~

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

Sec. 12. Minnesota Statutes 2018, section 256R.02, subdivision 8, is amended to read:

Subd. 8. **Capital assets.** "Capital assets" means a nursing facility's buildings, ~~attached fixtures~~ fixed equipment, land improvements, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 13. Minnesota Statutes 2018, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; planned closure rate adjustments under section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41; property taxes, special assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; rate adjustments for compensation-related costs for minimum wage changes under section 256R.49 provided on or after January 1, 2018; ~~and~~ Public Employees Retirement Association employer costs; and border city rate adjustments under section 256R.481.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 14. Minnesota Statutes 2018, section 256R.02, is amended by adding a subdivision to read:

Subd. 25a. **Interim payment rates.** "Interim payment rates" means the total operating and external fixed costs payment rates determined by anticipated costs and resident days reported on an interim cost report as described in section 256R.27.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 15. Minnesota Statutes 2018, section 256R.02, subdivision 33, is amended to read:

Subd. 33. **Nursing facility.** "Nursing facility" or "facility" means a facility with a medical assistance provider agreement that is licensed as a nursing home under chapter 144A or as a boarding care home under sections 144.50 to 144.56.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 16. Minnesota Statutes 2018, section 256R.02, is amended by adding a subdivision to read:

Subd. 47a. **Settle-up payment rates.** "Settle-up payment rates" means the total operating and external fixed costs payment rates determined by actual allowable costs and resident days reported on a settle-up cost report as described under section 256R.27.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 17. Minnesota Statutes 2018, section 256R.21, is amended by adding a subdivision to read:

Subd. 5. **Total payment rate for new facilities.** For a new nursing facility created under section 144A.071, subdivisions 2 and 3, the total payment rate must be determined according to section 256R.27.

EFFECTIVE DATE. This section is effective for projects approved by the commissioner of health on or after March 1, 2020.

Sec. 18. Minnesota Statutes 2018, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

(a) The payment rate for external fixed costs is the sum of the amounts in paragraphs (b) to ~~(n)~~ (o).

(b) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day. For a facility licensed as both a nursing home and a boarding care home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(c) The portion related to the licensure fee under section 144.122, paragraph (d), is the amount of the fee divided by the sum of the facility's resident days.

(d) The portion related to development and education of resident and family advisory councils under section 144A.33 is $5 per resident day divided by 365.

(e) The portion related to scholarships is determined under section 256R.37.

(f) The portion related to planned closure rate adjustments is as determined under section 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

(g) The portion related to consolidation rate adjustments shall be as determined under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.

(h) The portion related to single-bed room incentives is as determined under section 256R.41.

(i) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the ~~actual~~ allowable amounts divided by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

(j) The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

(k) The portion related to the Public Employees Retirement Association is ~~actual~~ allowable costs divided by the sum of the facility's resident days.

(l) The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

(m) The portion related to performance-based incentive payments is the amount determined under section 256R.38.

(n) The portion related to special dietary needs is the amount determined under section 256R.51.

(o) The portion related to the rate adjustments for border city facilities is the amount determined under section 256R.481.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020, except paragraph (o) is effective for rate years beginning on or after January 1, 2021.

Sec. 19. Minnesota Statutes 2018, section 256R.26, is amended to read:

256R.26 PROPERTY PAYMENT RATE.

Subdivision 1. **Determination of the limited undepreciated replacement cost.** ~~The property payment rate for a nursing facility is the property rate established for the facility under sections 256B.431 and 256B.434.~~ A facility's limited URC is the lesser of:

(1) the facility's URC from the appraisal; or

(2) the product of (i) the number of the facility's licensed beds three months prior to the beginning of the rate year, (ii) the construction cost per square foot value, and (iii) 1,000 square feet.

Subd. 2. **Determination of limited undepreciated replacement cost ratio.** A facility's limited URC ratio is the facility's limited URC as determined in subdivision 1 divided by the facility's URC.

Subd. 3. **Determination of limited depreciated replacement cost.** A facility's limited DRC is the product of the facility's DRC and the facility's limited URC ratio as determined in subdivision 2.

Subd. 4. **Determination of land and land improvement value.** A facility's land and land improvement value is the facility's limited URC as determined in subdivision 1 multiplied by 0.05.

Subd. 5. **Determination of annual fair rental value.** A facility's annual fair rental value is the product of:

(1) the sum of the facility's limited DRC as determined in subdivision 3 and the land and land improvement value as determined in subdivision 4; multiplied by

(2) the rental rate.

Subd. 6. **Determination of fair rental value property rate.** A facility's fair rental value property rate is the quotient of:

(1) the facility's annual fair rental value as determined in subdivision 5; divided by

(2) the product of the facility's capacity days and 0.88.

Subd. 7. **Determination of equipment allowance rate.** A facility's equipment allowance rate is the quotient of:

(1) the product of (i) the equipment allowance per bed value, (ii) the facility's number of licensed beds, and (iii) the rental rate; divided by

(2) the product of the facility's capacity days and 0.88.

Subd. 8. **Determination of total property payment rate.** Except as provided in subdivision 9, paragraph (a), a facility's total property payment rate is the sum of the facility's fair rental value property rate as determined in subdivision 6 and the facility's equipment allowance rate as determined in subdivision 7.

Subd. 9. **Transition period.** (a) A facility's property payment rate is the property rate established for the facility under sections 256B.431 and 256B.434 until the facility's property rate is transitioned upon completion of any project authorized under section 144A.071, subdivision 3 or 4d; or 144A.073, subdivision 3, to the fair rental value property rate calculated under this chapter.

(b) Effective the first day of the first month of the calendar quarter after the completion of the project described in paragraph (a), the commissioner shall transition a facility to the property payment rate calculated under this chapter. The initial rate year ends on December 31 and may be less than a full 12-month period. The commissioner shall schedule an appraisal within 90 days of the commissioner receiving notification from the facility that the project is completed. The commissioner shall apply the property payment rate determined after the appraisal retroactively to the first day of the first month of the calendar quarter after the completion of the project.

(c) Upon a facility's transition to the fair rental value property rates calculated under this chapter, the facility's total property payment rate under subdivision 8 shall be the only payment for costs related to capital assets, including depreciation, interest and lease expenses for all depreciable assets, including moveable equipment, land improvements, and land. Facilities with property payment rates established under subdivisions 1 to 8 are not eligible for planned closure rate adjustments under section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41; and the property rate inflation adjustment under section 256B.434, subdivision 4. The commissioner shall remove any of these incentives from the facility's existing rate upon the facility transitioning to the fair rental value property rates calculated under this chapter.

Subd. 10. **New nursing facilities.** A nursing facility new to the medical assistance program must, upon completion of construction of the nursing facility, have the building and fixed equipment appraised by a property appraisal firm selected by the commissioner or, if not newly constructed, upon entering the medical assistance program. The commissioner shall schedule an appraisal within 90 days of notification from the facility that the facility

has become Medicaid certified. The commissioner shall apply the property payment rate determined after the initial appraisal retroactively to the Medicaid certification date.

EFFECTIVE DATE. Subdivisions 1 to 10 are effective for rate years beginning on or after January 1, 2020, for nursing facilities that completed projects authorized after March 1, 2020, under Minnesota Statutes, section 144A.071, subdivision 3 or 4d; or 144A.073, subdivision 3.

Sec. 20. **[256R.261] PROPERTY RATE DEFINITIONS.**

Subdivision 1. **Definitions.** For purposes of sections 256R.26 to 256R.267, the terms in this section have the meanings given unless otherwise provided for in this chapter.

Subd. 2. **Addition.** "Addition" means an extension, enlargement, or expansion of the nursing facility for the purpose of increasing the number of licensed beds or improving resident care.

Subd. 3. **Appraisal.** "Appraisal" means an evaluation of the nursing facility's physical real estate conducted by a property appraisal firm selected by the commissioner to establish the valuation of a building and fixed equipment. An appraisal does not include an evaluation of moveable equipment, land, or land improvements. An appraisal may include an evaluation of shared space provided the valuation is subsequently adjusted for any shared area included in the depreciated replacement cost and undepreciated replacement cost that is not used exclusively for nursing facility purposes.

Subd. 4. **Building.** "Building" means the physical plant and fixed equipment used directly for resident care and licensed under chapter 144A or sections 144.50 to 144.56. Building excludes buildings or portions of buildings used by central, affiliated, or corporate offices.

Subd. 5. **Capacity days.** "Capacity days" means the number of licensed beds within the nursing facility multiplied by 365 days.

Subd. 6. **Construction cost per square foot value.** "Construction cost per square foot value" means the RSMeans nursing home cost per square foot of floor area for a 40,000 square foot nursing home with precast concrete and bearing walls multiplied by the commercial location factor for Minneapolis as indicated in the most recently available edition of the Square Foot Costs with RSMeans Data, as published by Gordian.

Subd. 7. **Commercial valuation system.** "Commercial valuation system" means the commercially available building valuation system selected by the commissioner for use in all appraisals.

Subd. 8. **Depreciable movable equipment.** "Depreciable movable equipment" means the standard movable care equipment and support service equipment generally used in nursing facilities. Depreciable movable equipment includes equipment specified in the major movable equipment table of the depreciation guidelines.

Subd. 9. **Depreciated replacement cost or DRC.** "Depreciated replacement cost" or "DRC" means the depreciated replacement cost determined by an appraisal using the commercial valuation system selected by the commissioner. DRC excludes costs related to parking structures.

Subd. 10. **Depreciation expense.** "Depreciation expense" means the portion of a capital asset deemed to be consumed or expired over the life of the asset.

Subd. 11. **Depreciation guidelines.** "Depreciation guidelines" means the most recent publication of "Estimated Useful Lives of Depreciable Hospital Assets" issued by the American Hospital Association.

Subd. 12. **Equipment allowance.** "Equipment allowance" means the component of the property payment rate that is a payment for the use of depreciable movable equipment.

Subd. 13. **Equipment allowance per bed value.** The equipment allowance per bed value is $10,000 adjusted annually for rate years beginning on or after January 1, 2021, by the percentage change indicated by the urban consumer price index for Minneapolis-St. Paul, as published by the Bureau of Labor Statistics (series 1967=100) for the two previous Julys. The computation for this annual adjustment is based on the data that is publicly available on November 1 immediately preceding the start of the rate year.

Subd. 14. **Fair rental value system.** "Fair rental value system" means a system that establishes a price for the use of a space based on an appraised value of the property. The price is established without consideration of the actual accounting cost to construct or remodel the property. The price is the nursing facility value, subject to limits, multiplied by an established rental rate.

Subd. 15. **Fixed equipment.** "Fixed equipment" means equipment affixed to the building and not subject to transfer, including but not limited to wiring, electrical fixtures, plumbing, elevators, and heating and air conditioning systems.

Subd. 16. **Land improvement.** "Land improvement" means improvement to the land surrounding the nursing facility directly used for nursing facility operations as specified in the land improvements table of the depreciation guidelines, if replacement of the land improvement is the responsibility of the nursing facility. Land improvement includes

construction of auxiliary buildings including sheds, garages, storage buildings, and parking structures. Parking structures are a land improvement and included only in the land and land improvement value under section 256R.26, subdivision 4. Parking structures are not to be included in either the undepreciated replacement cost or depreciated replacement cost.

Subd. 17. **Rental rate.** (a) "Rental rate" means the percentage applied to the allowable value of the building, moveable, and fixed equipment per year in the property payment rate calculation.

(b) The rental rate is the sum of the 20-year treasury bond rate as published in the Federal Reserve Bulletin using the average for the calendar year preceding the rate year based on data publicly available on November 1 each year, plus a risk value of three percent.

(c) Regardless of the result in paragraph (b), the rental rate must not be less than 7.5 percent or more than 12 percent.

Subd. 18. **Shared area.** "Shared area" means square footage that a nursing facility shares with a nonnursing facility operation to provide a support service. The appraisals initially may include the full value of all shared areas. The undepreciated replacement cost and depreciated replacement cost established by the appraisals must be adjusted in the final nursing facility values to reflect only the nursing facility usage. The adjustment must be based on a Medicare-approved allocation basis for the type of service provided by each area. Shared areas outside the appraised space must be added to DRC, URC, and related square footage using the average of each value from the space in the appraisal.

Subd. 19. **Threshold project.** "Threshold project" means additions to a building or fixed equipment that are subject to the threshold project limits under section 256R.267, paragraph (a). Threshold project excludes land, land improvements, and depreciable movable equipment purchases.

Subd. 20. **Undepreciated replacement cost or URC.** "Undepreciated replacement cost" or "URC" means the undepreciated replacement cost determined by the appraisal for building and fixed equipment using the commercial valuation system and appraisal firm.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 21. **[256R.265] APPRAISALS AND DETERMINATION OF REPLACEMENT COSTS.**

Subdivision 1. **Selection of valuation system and appraisal firms.** The commissioner shall select a commercial valuation system that property appraisal firms selected by the

commissioner must utilize for all nursing facility property appraisals. The commissioner shall use appraisal reports produced by commissioner-selected appraisal firms using the commissioner-selected commercial valuation system for the purposes of rate setting under section 256R.26, subdivisions 1 to 8. The commissioner shall not adjust or substitute any alternative appraisal of properties.

Subd. 2. **Appraised valuations generally.** The property appraisal firm selected by the commissioner shall determine the appraised valuation of a building and fixed equipment. The appraisal firm shall not include depreciable movable equipment, land, land improvements, or the physical plant for central office operations in the appraised valuation of the nursing facility. Appraisals are not intended to exactly reflect market value.

Subd. 3. **Appraisal reports.** Appraisal firms selected by the commissioner shall produce a report detailing both the DRC and URC of the nursing facility.

Subd. 4. **Appraised valuations of shared space.** Selected appraisal firms may include the full value of all shared areas in an initial appraisal but must adjust the nursing facility valuation of any shared area included in the square footage, DRC, and URC that are not used for nursing facility purposes to reflect only the nursing facility usage of shared areas. Selected appraisal firms shall adjust facility valuation for shared areas using a Medicare-approved allocation basis for the type of service provided in each area. Shared areas outside the appraised space must be added to the DRC, URC, and related square footage using the average of each value from the space in the appraisal.

Subd. 5. **Review and appeal of appraisal reports.** A nursing facility may appeal a finding of fact in the appraisal report to the appraiser within 20 calendar days after receipt of the appraisal report and request revision.

Subd. 6. **Update of replacement costs.** When a facility's most recent physical appraisal was completed more than 12 months before the start of the rate year, the appraisal firm shall use the commercial valuation system to update the most recent DRC and URC of the nursing facility and the commissioner shall use the updated DRC and URC to determine the total property payment rate under section 256R.26. Updated DRC and URC are updates only and not subject to revisions of any of the original valuations or appeal to the appraiser by the facility.

Subd. 7. **Appraisal frequency.** After a facility's initial rate year described in section 256R.26, subdivision 9, paragraph (b), the commissioner shall ensure that a selected appraisal firm conducts a new physical appraisal of the facility at least once every three years using a commercial valuation system.

Subd. 8. **Limitation on appraisal values.** After the initial rate year described in section 256R.26, subdivision 9, paragraph (b), the increase in the URC for each subsequent appraisal shall not exceed $2,000 per bed per year since the most recent physical appraisal, plus any projects completed under section 256R.267 since the most recent appraisal. Any limitation to the URC must be applied in the same proportion to the DRC. The commissioner shall update annually on January 1 the per-bed per-year limit on the increase in the URC in this subdivision by the annual percent change in the construction cost per square foot value.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 22. **[256R.267] THRESHOLD PROJECT PROPERTY PAYMENT RATE INTERIM ADJUSTMENTS.**

(a) A facility reimbursed under section 256R.26, subdivisions 1 to 8, may receive a property payment rate interim adjustment for threshold projects the cumulative cost of which during the three years between physical appraisals is between the following threshold project cost limits:

(1) the lesser of $316,816 or $10,000 per bed in service; and

(2) the greater of $1,620,943 or $20,000 per bed in service.

The commissioner shall update the threshold project cost limits each January 1 by the annual percent change in the construction cost per square foot value based on the information that is publicly available on November 1 immediately preceding the rate year.

(b) A facility seeking a property payment rate interim adjustment must request an adjustment after the threshold project is completed. The nursing facility or the lease holder must have incurred the threshold project cost subsequent to the facility's last physical appraisal. The nursing facility must submit to the commissioner all building and fixed equipment cost data related to the project within 90 days of completing the project.

(c) Effective January 1 or July 1, whichever occurs first after a facility completes a threshold project and requests the property payment rate interim adjustment, the commissioner shall add the allowable reported threshold project costs to the facility's URC under section 256R.26, subdivision 1, and to the DRC under section 256R.26, subdivision 3, before calculating an adjusted property payment rate under section 256R.26. The commissioner shall not include in the facility's limited URC threshold project costs reported to the commissioner between physical appraisals that exceed the maximum cumulative project cost limits described in paragraph (a).

(d) In subsequent property payment rate calculations following the completion of a physical appraisal, the commissioner shall eliminate any interim adjustment to the DRC and URC under paragraph (c).

(e) At the option of the commissioner, the commissioner may adjust the appraisal schedule for a nursing facility that has completed a threshold project.

(f) If more or less than three years pass between a facility's physical appraisals, the commissioner shall prorate the facility's threshold project cost limits accordingly.

(g) After the initial rate year project adjustments are allowed once annually based on the previous project completion date.

(h) Two threshold projects may not be conducted at the same time. Purchases for a second project must be made after the completion date of the first project.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 23. **[256R.27] INTERIM AND SETTLE-UP PAYMENT RATES.**

Subdivision 1. **Generally.** (a) The commissioner shall determine the interim payment rates and settle-up payment rates for a newly constructed nursing facility, or a nursing facility with an increase in licensed capacity of 50 percent or more, according to subdivisions 2 and 3.

(b) The nursing facility must submit a written application to the commissioner to receive interim payment rates. In its application, the nursing facility must state any reasons for noncompliance with this chapter.

(c) The effective date of the interim payment rates is the date the nursing facility is certified for the medical assistance program.

(d) The nursing facility must continue to receive the interim payment rates until the settle-up payment rates are determined under subdivision 3.

(e) For the 15-month period following the settle-up reporting period, the settle-up payment rates must be determined according to subdivision 3, paragraph (c).

(f) The settle-up payment rates are effective retroactively to the beginning of the interim payment rates and are effective until the end of the interim rate period.

(g) The total operating and external fixed costs payment rate for the rate year beginning January 1 following the 15-month period in paragraph (e) must be determined under this chapter.

Subd. 2. **Determination of interim payment rates.** (a) The nursing facility shall submit an interim cost report in a format similar to the Minnesota Statistical and Cost Report and other supporting information as required by this chapter for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The interim cost report must include the nursing facility's anticipated interim costs and anticipated interim resident days for each resident class in the interim cost report. The anticipated interim resident days for each resident class is multiplied by the weight for that resident class to determine the anticipated interim standardized days as defined in section 256R.02, subdivision 50, and resident days as defined in section 256R.02, subdivision 45, for the reporting period.

(b) The interim payment rates are determined according to sections 256R.21 to 256R.25, except that:

(1) the anticipated interim costs and anticipated interim resident days reported on the interim cost report and the anticipated interim standardized days as defined by section 256R.02, subdivision 50, must be used for the interim;

(2) the commissioner shall use anticipated interim costs and anticipated interim standardized days in determining the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use anticipated interim costs and anticipated interim resident days in determining the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use anticipated interim costs and anticipated interim resident days to determine the allowable historical external fixed costs per day under section 256R.25, paragraphs (b) to (k);

(5) the total care-related payment rate limits established in section 256R.23, subdivision 5, and in effect at the beginning of the interim period must be increased by ten percent; and

(6) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

Subd. 3. **Determination of settle-up payment rates.** (a) When the interim payment rates begin between May 1 and September 30, the nursing facility shall file settle-up cost

reports for the period from the beginning of the interim payment rates through September 30 of the following year.

(b) When the interim payment rates begin between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rates to the first September 30 following the beginning of the interim payment rates.

(c) The settle-up payment rates are determined according to sections 256R.21 to 256R.25, except that:

(1) the allowable costs and resident days reported on the settle-up cost report and the standardized days as defined by section 256R.02, subdivision 50, must be used for the interim and settle-up period;

(2) the commissioner shall use the allowable costs and standardized days in clause (1) to determine the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use the allowable costs and the allowable resident days to determine both the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use the allowable costs and the allowable resident days to determine the allowable historical external fixed costs per day under section 256R.25, paragraphs (b) to (k);

(5) the total care-related payment limits established in section 256R.23, subdivision 5, are the limits for the settle-up reporting periods. If the interim period includes more than one July 1 date, the commissioner shall use the total care-related payment rate limit established in section 256R.23, subdivision 5, increased by ten percent for the second July 1 date; and

(6) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2020.

Sec. 24. Minnesota Statutes 2018, section 256R.44, is amended to read:

256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL NECESSITY.

(a) The amount paid for a private room is 111.5 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition, except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity.

(b) For a nursing facility with a total property payment rate determined under section 256R.26, subdivision 8, the amount paid for a private room is 111.5 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity.

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

Sec. 25. **[256R.481] RATE ADJUSTMENTS FOR BORDER CITY FACILITIES.**

(a) The commissioner shall allow each nonprofit nursing facility located within the boundaries of the city of Breckenridge or Moorhead prior to January 1, 2015, to apply once annually for a rate add-on to the facility's external fixed costs payment rate.

(b) A facility seeking an add-on to its external fixed costs payment rate under this section must apply annually to the commissioner to receive the add-on. A facility must submit the application within 60 calendar days of the effective date of any add-on under this section. The commissioner may waive the deadlines required by this paragraph under extraordinary circumstances.

(c) The commissioner shall provide the add-on to each eligible facility that applies by the application deadline.

(d) The add-on to the external fixed costs payment rate is the difference on January 1 of the median total payment rate for case mix classification PA1 of the nonprofit facilities located in an adjacent city in another state and in cities contiguous to the adjacent city minus

the eligible nursing facility's total payment rate for case mix classification PA1 as determined under section 256R.22, subdivision 4.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2021.

Sec. 26. Minnesota Statutes 2018, section 256R.50, subdivision 6, is amended to read:

Subd. 6. **Determination of rate adjustment.** (a) If the amount determined in subdivision 5 is less than or equal to the amount determined in subdivision 4, the commissioner shall allow a total payment rate equal to the amount used in subdivision 5, clause (3).

(b) If the amount determined in subdivision 5 is greater than the amount determined in subdivision 4, the commissioner shall allow a rate with a case mix index of 1.0 that when used in subdivision 5, clause (3), results in the amount determined in subdivision 5 being equal to the amount determined in subdivision 4.

(c) If the commissioner relies upon provider estimates in subdivision 5, clause (1) or (2), then annually, for three years after the rates determined in this section take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and the facility average case mix index used in this section and shall reduce the total payment rate if the factors used result in medical assistance costs exceeding the amount in subdivision 4. If the actual medical assistance costs exceed the estimates by more than five percent, the commissioner shall also recover the difference between the estimated costs in subdivision 5 and the actual costs according to section 256B.0641. The commissioner may require submission of data from the receiving facility needed to implement this paragraph.

(d) When beds approved for relocation are put into active service at the destination facility, rates determined in this section must be adjusted by any adjustment amounts that were implemented after the date of the letter of approval.

(e) Rate adjustments determined under this subdivision expire after three full rate years following the effective date of the rate adjustment. This subdivision expires when the final rate adjustment determined under this subdivision expires.

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

Sec. 27. **DIRECTION TO COMMISSIONER; CLEAN ENERGY PILOT PROJECT.**

(a) The commissioner shall develop a pilot project to reduce overall energy consumption and evaluate the financial impacts associated with property assessed clean energy (PACE) approved projects in nursing facilities.

(b) Notwithstanding Minnesota Statutes, section 256R.02, subdivision 48a, the commissioner may make payments to facilities for the allowable costs of special assessments for approved energy-related program payments authorized under Minnesota Statutes, sections 216C.435 and 216C.436.

(c) The commissioner shall approve proposals through a contract which shall specify the level of payment, provided that each facility demonstrates:

(1) completion of a facility-specific energy assessment or energy audit and recommended energy conservation measures that, in aggregate, meet the cost-effectiveness requirements of Minnesota Statutes, section 216B.241;

(2) a completed PACE application and recommended approval by a PACE program administrator authorized under Minnesota Statutes, sections 216C.435 and 216C.436; and

(3) the facility's reported spending on utilities per resident day since calendar year 2016 is higher than average for similar facilities.

(d) Payments to facilities under this section shall be in the form of time-limited rate adjustments which shall be included in the external fixed costs payment rate under Minnesota Statutes, section 256R.25. The commissioner shall select from facilities that meet the requirements of paragraph (c) using a competitive application process.

(e) Allowable costs for special assessments for approved energy-related program payments cannot exceed the amount of debt service for net expenditures for the project and must meet the cost-effective energy improvements requirements described in Minnesota Statutes, section 216C.435, subdivision 3a. Any credits or rebates related to the project must be offset. A project cost is not an allowable cost on the cost report as a special assessment if it has been or will be used to increase the facility's property rate.

(f) The external fixed costs payment rate for the PACE allowable costs shall be reduced by an amount equal to the utility per diem included in the other operating payment rate under Minnesota Statutes, section 256R.24, that is associated with the energy project.

(g) In fiscal years 2020 and 2021, the commissioner of human services may approve assessed clean energy pilot projects under this section, for which the cumulative state share of medical assistance costs does not exceed $125,000.

(h) Notwithstanding any other law to the contrary, money available under Minnesota Statutes, section 144A.073, shall be used to pay the medical assistance cost for the external fixed rate increase in this section.

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

Sec. 28. **DIRECTION TO COMMISSIONER; ELDERLY WAIVER CUSTOMIZED LIVING SERVICE PROVIDERS.**

(a) The commissioner of human services shall develop incentive-based grants to be available during fiscal years 2020 and 2021 only for elderly waiver customized living service providers for achieving outcomes specified in a contract. The commissioner may solicit proposals from providers and implement those that, on a competitive basis, best meet the state's policy objectives, giving preference to providers that serve at least 75 percent elderly waiver participants. The commissioner shall limit expenditures under this subdivision to the amount appropriated for this purpose.

(b) In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) provide more efficient, higher quality services;

(2) encourage home and community-based services providers to innovate;

(3) equip home and community-based services providers with organizational tools and expertise to improve their quality;

(4) incentivize home and community-based services providers to invest in better services; and

(5) disseminate successful performance improvement strategies statewide.

Sec. 29. **REVISOR INSTRUCTION.**

In Minnesota Statutes, the revisor of statutes shall renumber the nursing facility contracting provisions that are currently coded as section 256B.434, subdivisions 1 and 3, as amended by this act, as a section in chapter 256R and revise any statutory cross-references consistent with that recodification.

Sec. 30. **REPEALER.**

(a) Minnesota Statutes 2018, section 256B.431, subdivisions 3i, 15, and 16, are repealed effective January 1, 2020.

(b) Minnesota Statutes 2018, section 256B.434, subdivisions 6 and 10, are repealed effective the day following final enactment.

(c) Minnesota Statutes 2018, section 256R.53, subdivision 2, is repealed effective January 1, 2021.

(d) Minnesota Rules, parts 9549.0057; and 9549.0060, subpart 14, are repealed effective January 1, 2020.

ARTICLE 5
DISABILITY SERVICES

Section 1. Minnesota Statutes 2018, section 237.50, subdivision 4a, is amended to read:

Subd. 4a. **Deaf.** "Deaf" means a hearing loss of such severity that the ~~individual~~ person must depend primarily upon visual communication such as writing, lip reading, sign language, and gestures.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 2. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to read:

Subd. 4c. **Discounted telecommunications or Internet services.** "Discounted telecommunications or Internet services" means private, nonprofit, and public programs intended to subsidize or reduce the monthly costs of telecommunications or Internet services for a person who meets a program's eligibility requirements.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 237.50, subdivision 6a, is amended to read:

Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing loss resulting in a functional limitation, but not to the extent that the ~~individual~~ person must depend primarily upon visual communication in all interactions.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 4. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to read:

Subd. 6b. **Interconnectivity product.** "Interconnectivity product" means a device, accessory, or application for which the primary function is use with a telecommunications device. Interconnectivity product may include a cell phone amplifier, hearing aid streamer, Bluetooth-enabled device that connects to a wireless telecommunications device, advanced communications application for a smartphone, or other applicable technology.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 5. Minnesota Statutes 2018, section 237.50, subdivision 10a, is amended to read:

Subd. 10a. **Telecommunications device.** "Telecommunications device" means a device that (1) allows a person with a communication disability to have access to telecommunications services as defined in subdivision 13, and (2) is specifically selected by the Department of Human Services for its capacity to allow persons with communication disabilities to use telecommunications services in a manner that is functionally equivalent to the ability of ~~an individual~~ a person who does not have a communication disability. A telecommunications device may include a ring signaler, an amplified telephone, a hands-free telephone, a text telephone, a captioned telephone, a wireless device, a device that produces Braille output for use with a telephone, and any other device the Department of Human Services deems appropriate.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 6. Minnesota Statutes 2018, section 237.50, subdivision 11, is amended to read:

Subd. 11. **Telecommunications Relay Services.** "Telecommunications Relay Services" or "TRS" means the telecommunications transmission services required under Federal Communications Commission regulations at Code of Federal Regulations, title 47, sections 64.604 to 64.606. TRS allows ~~an individual~~ a person who has a communication disability to use telecommunications services in a manner that is functionally equivalent to the ability of ~~an individual~~ a person who does not have a communication disability.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 237.51, subdivision 1, is amended to read:

Subdivision 1. **Creation.** (a) The commissioner of commerce shall:

(1) administer through interagency agreement with the commissioner of human services a program to distribute telecommunications devices and interconnectivity products to eligible persons who have communication disabilities; and

(2) contract with one or more qualified vendors that serve persons who have communication disabilities to provide telecommunications relay services.

(b) For purposes of sections 237.51 to 237.56, the Department of Commerce and any organization with which it contracts pursuant to this section or section 237.54, subdivision 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 237.51, subdivision 5a, is amended to read:

Subd. 5a. **Commissioner of human services duties.** (a) In addition to any duties specified elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

(1) define economic hardship, special needs, and household criteria so as to determine the priority of eligible applicants for initial distribution of devices and products and to determine circumstances necessitating provision of more than one telecommunications device per household;

(2) establish a method to verify eligibility requirements;

(3) establish specifications for telecommunications devices and interconnectivity products to be provided under section 237.53, subdivision 3;

(4) inform the public and specifically persons who have communication disabilities of the program; ~~and~~

(5) provide devices and products based on the assessed need of eligible applicants~~.~~; and

(6) assist a person with completing an application for discounted telecommunications or Internet services.

(b) The commissioner may establish an advisory board to advise the department in carrying out the duties specified in this section and to advise the commissioner of commerce in carrying out duties under section 237.54. If so established, the advisory board must include, at a minimum, the following persons:

(1) at least one member who is deaf;

(2) at least one member who has a speech disability;

(3) at least one member who has a physical disability that makes it difficult or impossible for the person to access telecommunications services; and

(4) at least one member who is hard-of-hearing.

(c) The membership terms, compensation, and removal of members and the filling of membership vacancies are governed by section 15.059. Advisory board meetings shall be held at the discretion of the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 237.52, subdivision 5, is amended to read:

Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

(1) expenses of the Department of Commerce, including personnel cost, public relations, advisory board members' expenses, preparation of reports, and other reasonable expenses not to exceed ten percent of total program expenditures;

(2) reimbursing the commissioner of human services for purchases made or services provided pursuant to section 237.53; and

(3) contracting for the provision of TRS required by section 237.54.

(b) All costs directly associated with the establishment of the program, the purchase and distribution of telecommunications devices~~,~~ and interconnectivity products, and the provision of TRS are either reimbursable or directly payable from the fund after authorization by the commissioner of commerce. The commissioner of commerce shall contract with one or more TRS providers to indemnify the telecommunications service providers for any fines imposed by the Federal Communications Commission related to the failure of the relay service to comply with federal service standards. Notwithstanding section 16A.41, the commissioner may advance money to the TRS providers if the providers establish to the commissioner's satisfaction that the advance payment is necessary for the provision of the service. The advance payment may be used only for working capital reserve for the operation of the service. The advance payment must be offset or repaid by the end of the contract fiscal year together with interest accrued from the date of payment.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 10. Minnesota Statutes 2018, section 237.53, is amended to read:

237.53 TELECOMMUNICATIONS ~~DEVICE~~ DEVICES AND INTERCONNECTIVITY PRODUCTS.

Subdivision 1. **Application.** A person applying for a telecommunications device or interconnectivity product under this section must apply to the program administrator on a form prescribed by the Department of Human Services.

Subd. 2. **Eligibility.** To be eligible to obtain a telecommunications device or interconnectivity product under this section, a person must:

(1) be able to benefit from and use the equipment for its intended purpose;

(2) have a communication disability;

(3) be a resident of the state;

(4) be a resident in a household that has a median income at or below the applicable median household income in the state, except a person who is deafblind applying for a Braille device may reside in a household that has a median income no more than 150 percent of the applicable median household income in the state; and

(5) be a resident in a household that has telecommunications service or that has made application for service and has been assigned a telephone number; or a resident in a residential care facility, such as a nursing home or group home where telecommunications service is not included as part of overall service provision.

Subd. 2a. **Assessment of needs.** After a person is determined to be eligible for the program, the commissioner of human services shall assess the person's telecommunications needs to determine: (1) the type of telecommunications device that provides the person with functionally equivalent access to telecommunications services; and (2) appropriate interconnectivity products for the person.

Subd. 3. **Distribution.** The commissioner of human services shall (1) purchase ~~and distribute~~ a sufficient number of telecommunications devices and interconnectivity products so that each eligible household receives appropriate devices and products as determined under section 237.51, subdivision 5a~~. The commissioner of human services shall~~, and (2) distribute the devices and products to eligible households free of charge.

Subd. 4. **Training; information; maintenance.** The commissioner of human services shall maintain the telecommunications devices and interconnectivity products until the warranty period expires, and provide training, without charge, to first-time users of the

devices. and products. The commissioner shall provide information about assistive communications devices and products that may benefit a program participant and about where a person may obtain or purchase assistive communications devices and products. Assistive communications devices and products include a pocket talker for a person who is hard-of-hearing, a communication board for a person with a speech disability, a one-to-one video communication application for a person who is deaf, and other devices and products designed to facilitate effective communication for a person with a communication disability.

Subd. 6. **Ownership.** Telecommunications devices and interconnectivity products purchased pursuant to subdivision 3, clause (1), are the property of the state of Minnesota. Policies and procedures for the return of distributed devices ~~from individuals who withdraw from the program or whose eligibility status changes~~ and products shall be determined by the commissioner of human services.

Subd. 7. **Standards.** The telecommunications devices distributed under this section must comply with the electronic industries alliance standards and be approved by the Federal Communications Commission. The commissioner of human services must provide each eligible person a choice of several models of devices, the retail value of which may not exceed $600 for a text telephone, and a retail value of $7,000 for a Braille device, or an amount authorized by the Department of Human Services for all other telecommunications devices ~~and~~, auxiliary equipment, and interconnectivity products it deems cost-effective and appropriate to distribute according to sections 237.51 to 237.56.

Subd. 9. **Discounted telecommunications or Internet services assistance.** The commissioner of human services shall assist a person who is applying for telecommunication devices and products in applying for discounted telecommunications or Internet services.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 11. Minnesota Statutes 2018, 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 welfare 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 access for disability inclusion, developmental ~~disability~~ disabilities, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, community alternative care, 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~~ disabilities waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental ~~disability~~ disabilities waiver plans;

(5) night supervision services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver ~~plan~~ plans;

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental ~~disability~~ disabilities, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only; ~~and~~

(7) individual community living support under section 256B.0915, subdivision 3j~~.~~; and

(8) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion, and developmental disability waiver plans.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare 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~~ positive support services as defined under the brain injury and community access for disability inclusion, community alternative care, and developmental disabilities waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental ~~disability~~ disabilities waiver ~~plan~~ plans; and

(iii) specialist services as defined under the current brain injury, community access for disability inclusion, community alternative care, and developmental ~~disability~~ disabilities waiver ~~plan~~ plans;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental ~~disability~~ disabilities waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans;

(iii) semi-independent living services; ~~and~~

~~(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;~~

(iv) individualized home support with training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(v) individualized home support with family training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental ~~disability~~ disabilities 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 access for disability inclusion 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) community residential services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans provided in a corporate child foster care residence, a community residential setting, or a supervised living facility;

(iv) family residential services as defined in the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans provided in a family child foster care residence or a family adult foster care residence; and

(v) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day services under sections 252.41 to 252.46, and as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(iii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental ~~disability~~ disabilities waiver plan; and

~~(iii)~~ (iv) prevocational services as defined under the brain injury ~~and~~, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(5) employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans; ~~and~~

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans~~.~~; and

(8) integrated community support as defined under the brain injury and community access for disability inclusion waiver plans beginning January 1, 2021, and community alternative care and developmental disability waiver plans beginning January 1, 2023.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

Subdivision 1. **Requirements for intensive support services.** Except for services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), a license holder providing intensive support services identified in section 245D.03, subdivision 1, paragraph (c), must comply with the requirements in this section and section 245D.07, subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), must comply with the requirements in section 245D.07, subdivision 2.

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

Sec. 13. Minnesota Statutes 2018, section 245D.071, subdivision 5, is amended to read:

Subd. 5. **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. At least once per year, or within 30 days of a written request by the person, the person's legal representative, or the case manager, 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 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) At least once per year, 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 to discuss how technology might be used to meet the person's desired outcomes. The coordinated service and support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision made related to the use of technology and a description of any further research that must be completed before a decision regarding the use of technology can be made. Nothing in this paragraph requires the coordinated service and support plan addendum to include the use of technology for the provision of services.

~~(b)~~ (c) 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 report available at the time of the progress review meeting. The report must be sent at least five working days prior to the progress review meeting if requested by the team in the coordinated service and support plan or coordinated service and support plan addendum.

~~(c)~~ (d) The license holder must send the coordinated service and support plan addendum to the person, the person's legal representative, and the case manager by mail within ten working days of the progress review meeting. Within ten working days of the mailing of the coordinated service and support plan addendum, 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.

~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and support plan and coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the coordinated service and support plan or coordinated service and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the coordinated service and support plan addendum becomes effective and remains in effect until the legal representative or case manager submits a written request to revise the coordinated service and support plan addendum.

Sec. 14. Minnesota Statutes 2018, section 245D.09, subdivision 5, is amended to read:

Subd. 5. **Annual training.** A license holder must provide annual training to direct support staff on the topics identified in subdivision 4, clauses (3) to (10). If the direct support staff has a first aid certification, annual training under subdivision 4, clause (9), is not required as long as the certification remains current. ~~A license holder must provide a minimum of 24 hours of annual training to direct service staff providing intensive services and having~~

~~fewer than five years of documented experience and 12 hours of annual training to direct service staff providing intensive services and having five or more years of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a) to (f). Training on relevant topics received from sources other than the license holder may count toward training requirements. A license holder must provide a minimum of 12 hours of annual training to direct service staff providing basic services and having fewer than five years of documented experience and six hours of annual training to direct service staff providing basic services and having five or more years of documented experience.~~

Sec. 15. Minnesota Statutes 2018, section 245D.09, subdivision 5a, is amended to read:

Subd. 5a. **Alternative sources of training.** ~~The commissioner may approve online training and competency-based assessments in place of a specific number of hours of training in the topics covered in subdivision 4. The commissioner must provide a list of preapproved trainings that do not need approval for each individual license holder.~~

Orientation or training received by the staff person from sources other than the license holder in the same subjects as identified in subdivision 4 may count toward the orientation and annual training requirements if received in the 12-month period before the staff person's date of hire. The license holder must maintain documentation of the training received from other sources and of each staff person's competency in the required area according to the requirements in subdivision 3.

Sec. 16. Minnesota Statutes 2018, section 245D.091, subdivision 2, is amended to read:

Subd. 2. **~~Behavior~~ Positive support professional qualifications.** A ~~behavior~~ positive support professional providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disabilities 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) person with a master's degree or PhD in one of the behavioral sciences or related fields with demonstrated expertise in positive support services, as determined by the person's needs as outlined in the person's community support plan; or

(vii) 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. 17. Minnesota Statutes 2018, section 245D.091, subdivision 3, is amended to read:

Subd. 3. **~~Behavior~~ Positive support analyst qualifications.** (a) A ~~behavior~~ positive support analyst providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disabilities 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; or

(3) be a board-certified behavior analyst or board-certified assistant behavior analyst by the Behavior Analyst Certification Board, Incorporated.

(b) In addition, a ~~behavior~~ positive support 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~~ conducting functional behavior assessments and designing, implementing, and evaluating effectiveness of positive practices behavior support strategies for people who exhibit challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;

(2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~ training prior to hire or within 90 calendar days of hire that includes:

(i) ten hours of instruction in functional assessment and functional analysis;

(ii) 20 hours of instruction in the understanding of the function of behavior;

(iii) ten hours of instruction on design of positive practices behavior support strategies;

(iv) 20 hours of instruction preparing written intervention strategies, designing data collection protocols, training other staff to implement positive practice strategies, summarizing and reporting program evaluation data, analyzing program evaluation data to identify design flaws in behavioral interventions or failures in implementation fidelity, and recommending enhancements based on evaluation data; and

(v) eight hours of instruction on principles of person-centered thinking;

~~(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)~~ (3) be determined by a ~~behavior~~ positive support 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~~ positive support; and

~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraph (b).

Sec. 18. Minnesota Statutes 2018, section 245D.091, subdivision 4, is amended to read:

Subd. 4. **~~Behavior~~ Positive support specialist qualifications.** (a) A ~~behavior~~ positive support specialist providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disabilities 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 training prior to hire or within 90 calendar days of hire that includes:

(i) a minimum of four hours of training in functional assessment;

~~(2) have received~~ (ii) 20 hours of instruction in the understanding of the function of behavior;

~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral support strategies; and

(iv) eight hours of instruction on principles of person-centered thinking;

~~(4)~~ (2) be determined by a ~~behavior~~ positive support 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~~ positive support; and

~~(5)~~ (3) be under the direct supervision of a ~~behavior~~ positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

Sec. 19. **[245D.12] INTEGRATED COMMUNITY SUPPORTS; SETTING CAPACITY REPORT.**

(a) The license holder providing integrated community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to the commissioner to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in section 256B.492.

(b) The license holder shall provide the setting capacity report on the forms and in the manner prescribed by the commissioner. The report must include:

(1) the address of the multifamily housing building where the license holder delivers integrated community supports and owns, leases, or has a direct or indirect financial relationship with the property owner;

(2) the total number of living units in the multifamily housing building described in clause (1) where integrated community supports are delivered;

(3) the total number of living units in the multifamily housing building described in clause (1), including the living units identified in clause (2); and

(4) the percentage of living units that are controlled by the license holder in the multifamily housing building by dividing clause (2) by clause (3).

(c) Only one license holder may deliver integrated community supports at the address of the multifamily housing building.

EFFECTIVE DATE. This section is effective upon the date of federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2018, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to chapter 259A or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 275 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~1.94~~ 1.65 percent of adjusted gross income at 275 percent of federal poverty guidelines and increases to ~~5.29~~ 4.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be ~~5.29~~ 4.5 percent of adjusted gross income;

(3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~5.29~~ 4.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ~~7.05~~ 5.99 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be ~~8.81~~ 7.49 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section.

The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 21. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services

for any person if the costs exceed the state share of the average medical assistance costs for services provided by intermediate care facilities for a person with a developmental disability for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any person if the costs exceed $1,500 in a state fiscal year. The commissioner may make payments to each county in quarterly installments. The commissioner may certify an advance of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement basis for reported expenditures and may be adjusted for anticipated spending patterns.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 22. Minnesota Statutes 2018, section 252.32, subdivision 1a, is amended to read:

Subd. 1a. **Support grants.** (a) Provision of support grants must be limited to families who require support and whose dependents are under the age of ~~21~~ 25 and who have been certified ~~disabled~~ as persons with disabilities under section 256B.055, subdivision 12, paragraphs (a), (b), (c), (d), and (e). Families who are receiving: home and community-based waivered services for persons with disabilities authorized under section 256B.092 or 256B.49; personal care assistance under section 256B.0652; or a consumer support grant under section 256.476 are not eligible for support grants.

New grant allocations, beginning July 1, 2019, are intended to support families with dependents age 14 through 24 to support transition-related activities.

Families whose annual adjusted gross income is $60,000 or more are not eligible for support grants except in cases where extreme hardship is demonstrated. Beginning in state fiscal year 1994, the commissioner shall adjust the income ceiling annually to reflect the projected change in the average value in the United States Department of Labor Bureau of Labor Statistics Consumer Price Index (all urban) for that year.

(b) Support grants may be made available as monthly subsidy grants and lump-sum grants.

(c) Support grants may be issued in the form of cash, voucher, and direct county payment to a vendor.

(d) Applications for the support grant shall be made by the legal guardian to the county social service agency. The application shall specify the needs of the families, the form of the grant requested by the families, and the items and services to be reimbursed.

EFFECTIVE DATE. This section is effective October 1, 2019.

Sec. 23. Minnesota Statutes 2018, section 252.41, subdivision 3, is amended to read:

Subd. 3. **Day ~~training and habilitation~~ services for adults with ~~developmental~~ disabilities.** (a) "Day ~~training and habilitation~~ services for adults with ~~developmental~~ disabilities" means services that:

(1) include supervision, training, assistance, support, ~~center-based~~ facility-based work-related activities, or other community-integrated activities designed and implemented in accordance with the ~~individual service and individual habilitation plans~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (b) and (c), and 256B.092, subdivision 1b, and Minnesota Rules, ~~parts~~ part 9525.0004 ~~to 9525.0036~~, subpart 12, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community; ~~and~~

(2) include day support services, prevocational services, day training and habilitation services, structured day services, and adult day services as defined in Minnesota's federally approved disability waiver plans; and

(3) are provided by a vendor licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28, subdivision 2, or 252.41 to 252.46, or Minnesota Rules, parts 9525.1200 to 9525.1330, to provide day ~~training and habilitation~~ services.

(b) Day ~~training and habilitation~~ services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

(c) Day ~~training and habilitation~~ services do not include employment exploration, employment development, or employment support services as defined in the home and community-based services waivers for people with disabilities authorized under sections 256B.092 and 256B.49.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 24. Minnesota Statutes 2018, section 252.41, subdivision 4, is amended to read:

Subd. 4. **Independence.** "Independence" means the extent to which persons with ~~developmental~~ disabilities exert control and choice over their own lives.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 25. Minnesota Statutes 2018, section 252.41, subdivision 5, is amended to read:

Subd. 5. **Integration.** "Integration" means that persons with ~~developmental~~ disabilities:

(1) use the same community resources that are used by and available to individuals who are not disabled;

(2) participate in the same community activities in which nondisabled individuals participate; and

(3) regularly interact and have contact with nondisabled individuals.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 26. Minnesota Statutes 2018, section 252.41, subdivision 6, is amended to read:

Subd. 6. **Productivity.** "Productivity" means that persons with ~~developmental~~ disabilities:

(1) engage in income-producing work designed to improve their income level, employment status, or job advancement; or

(2) engage in activities that contribute to a business, household, or community.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 27. Minnesota Statutes 2018, section 252.41, subdivision 7, is amended to read:

Subd. 7. **Regional center.** "Regional center" means any state-operated facility under the direct administrative authority of the commissioner that serves persons with ~~developmental~~ disabilities.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 28. Minnesota Statutes 2018, section 252.41, subdivision 9, is amended to read:

Subd. 9. **Vendor.** "Vendor" means a ~~nonprofit~~ legal entity that:

(1) is licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330, to provide day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities; and

(2) does not have a financial interest in the legal entity that provides residential services to the same person or persons to whom it provides day ~~training and habilitation~~ services.

This clause does not apply to regional treatment centers, state-operated, community-based programs operating according to section 252.50 until July 1, 2000, or vendors licensed prior to April 15, 1983.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 29. Minnesota Statutes 2018, section 252.42, is amended to read:

252.42 SERVICE PRINCIPLES.

The design and delivery of services eligible for reimbursement should reflect the following principles:

(1) services must suit a person's chronological age and be provided in the least restrictive environment possible, consistent with the needs identified in the person's ~~individual service and individual habilitation plans under~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 256B.092, subdivision 1b, and 245D.02, subdivision 4, paragraphs (b) and (c), and Minnesota Rules, parts 9525.0004 ~~to 9525.0036~~, subpart 12;

(2) a person with a ~~developmental~~ disability whose individual ~~service and individual habilitation plans~~ coordinated service and support plans and coordinated service and support plan addendums authorize employment or employment-related activities shall be given the opportunity to participate in employment and employment-related activities in which nondisabled persons participate;

(3) a person with a ~~developmental~~ disability participating in work shall be paid wages commensurate with the rate for comparable work and productivity except as regional centers are governed by section 246.151;

(4) a person with a ~~developmental~~ disability shall receive services which include services offered in settings used by the general public and designed to increase the person's active participation in ordinary community activities;

(5) a person with a ~~developmental~~ disability shall participate in the patterns, conditions, and rhythms of everyday living and working that are consistent with the norms of the mainstream of society.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 30. Minnesota Statutes 2018, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

The commissioner shall supervise ~~county boards'~~ lead agencies' provision of day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities. The commissioner shall:

(1) determine the need for day ~~training and habilitation~~ services under section ~~252.28~~ 256B.4914;

(2) establish payment rates as provided under section 256B.4914;

(3) adopt rules for the administration and provision of day ~~training and habilitation~~ services under ~~sections 252.41 to 252.46 and~~ sections 245A.01 to 245A.16 ~~and~~, 252.28, subdivision 2, or 252.41 to 252.46, or Minnesota Rules, parts 9525.1200 to 9525.1330;

(4) enter into interagency agreements necessary to ensure effective coordination and provision of day ~~training and habilitation~~ services;

(5) monitor and evaluate the costs and effectiveness of day ~~training and habilitation~~ services; and

(6) provide information and technical help to ~~county boards~~ lead agencies and vendors in their administration and provision of day ~~training and habilitation~~ services.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 31. Minnesota Statutes 2018, section 252.44, is amended to read:

252.44 ~~COUNTY~~ LEAD AGENCY BOARD RESPONSIBILITIES.

When the need for day ~~training and habilitation~~ services in a county or tribe has been determined under section 252.28, the board of commissioners for that ~~county~~ lead agency shall:

(1) authorize the delivery of services according to the ~~individual service and habilitation plans~~ coordinated service and support plans and coordinated service and support plan addendums required as part of the ~~county's~~ lead agency's provision of case management services under sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, and Minnesota Rules, parts 9525.0004 to 9525.0036~~. For calendar years for which section 252.46, subdivisions 2 to 10, apply, the county board shall not authorize a change in service days from the number of days authorized for the previous calendar year unless there is documentation for the change in the individual service plan. An increase in service days must also be supported by documentation that the~~

~~goals and objectives assigned to the vendor cannot be met more economically and effectively by other available community services and that without the additional days of service the individual service plan could not be implemented in a manner consistent with the service principles in section 252.42~~;

(2) ensure that transportation is provided or arranged by the vendor in the most efficient and reasonable way possible; and

(3) monitor and evaluate the cost and effectiveness of the services.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 32. Minnesota Statutes 2018, section 252.45, is amended to read:

252.45 VENDOR'S DUTIES.

A day service vendor enrolled with the commissioner is responsible for items under clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable under state and federal law. A vendor providing day ~~training and habilitation~~ services shall:

(1) provide the amount and type of services authorized in the individual service plan under coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (b) and (c), and 256B.092, subdivision 1b, and Minnesota Rules, ~~parts~~ part 9525.0004 ~~to 9525.0036~~, subpart 12;

(2) design the services to achieve the outcomes assigned to the vendor in the ~~individual service plan~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

(3) provide or arrange for transportation of persons receiving services to and from service sites;

(4) enter into agreements with community-based intermediate care facilities for persons with developmental disabilities to ensure compliance with applicable federal regulations; and

(5) comply with state and federal law.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 33. Minnesota Statutes 2018, section 256.9365, is amended to read:

256.9365 PURCHASE OF ~~CONTINUATION~~ HEALTH CARE COVERAGE FOR ~~AIDS PATIENTS~~ PEOPLE LIVING WITH HIV.

Subdivision 1. **Program established.** The commissioner of human services shall establish a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions, including co-payments, deductibles, and coinsurance for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual is responsible, if the individual is responsible for at least 50 percent of the cost of the premium, or pay the individual plan premium~~ health insurance premiums and prescription cost sharing, including co-payments and deductibles required under section 256B.0631. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents or is paid by the individual's employer.

Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must ~~satisfy the following requirements:~~ meet all eligibility requirements for Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87, and enroll in the Minnesota Ryan White program.

~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or physician assistant's statement verifying that the applicant is infected with HIV and is, or within three months is likely to become, too ill to work in the applicant's current employment because of HIV-related disease;~~

~~(2) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

~~(3) the applicant must not own assets with a combined value of more than $25,000; and~~

~~(4) if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan.~~

Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan premiums under ~~subdivision 2, clause (5),~~ this section must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

Sec. 34. Minnesota Statutes 2018, section 256B.0658, is amended to read:

256B.0658 HOUSING ACCESS GRANTS.

The commissioner of human services shall award through a competitive process contracts for grants to public and private agencies to support and assist individuals ~~eligible for publicly funded home and community-based services, including state plan home care~~ with a disability as defined in section 256B.051, subdivision 2, paragraph (e), to access housing. Grants may be awarded to agencies that may include, but are not limited to, the following supports: assessment to ensure suitability of housing, accompanying an individual to look at housing, filling out applications and rental agreements, meeting with landlords, helping with Section 8 or other program applications, helping to develop a budget, obtaining furniture and household goods, if necessary, and assisting with any problems that may arise with housing.

Sec. 35. Minnesota Statutes 2018, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified assessor may complete the assessment defined in this subdivision. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update

must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(b) This subdivision expires when notification is given by the commissioner as described in section 256B.0911, subdivision 3a.

Sec. 36. Minnesota Statutes 2018, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

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

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete 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. Personal care assistant 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 personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

(d) Personal care assistance services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides covered services to a recipient who qualifies for 12 or more hours per day of personal care assistance services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 37. Minnesota Statutes 2018, section 256B.0659, subdivision 13, is amended to read:

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency ~~and~~, meet the definition of qualified professional under section 256B.0625, subdivision 19c, and enroll with the department as a qualified professional after clearing a background study. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

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

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

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) Effective July 1, 2011, the qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States

Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

Sec. 38. Minnesota Statutes 2018, section 256B.0659, is amended by adding a subdivision to read:

Subd. 17a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for 12 or more hours of personal care assistance services per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d). The enhanced rate for personal care assistance services includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2019, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54, that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of personal care assistance services per day.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 39. Minnesota Statutes 2018, section 256B.0659, subdivision 19, is amended to read:

Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under personal care assistance choice, the recipient or responsible party shall:

(1) recruit, hire, schedule, and terminate personal care assistants according to the terms of the written agreement required under subdivision 20, paragraph (a);

(2) develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed;

(3) orient and train the personal care assistant with assistance as needed from the qualified professional;

(4) effective January 1, 2010, supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 180 days;

(5) monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional;

(6) engage in an annual face-to-face reassessment to determine continuing eligibility and service authorization; and

(7) use the same personal care assistance choice provider agency if shared personal assistance care is being used.

(b) The personal care assistance choice provider agency shall:

(1) meet all personal care assistance provider agency standards;

(2) enter into a written agreement with the recipient, responsible party, and personal care assistants;

(3) not be related as a parent, child, sibling, or spouse to the recipient or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including, but not limited to, workers' compensation ~~and~~, unemployment insurance, and labor market data required under section 256B.4912, subdivision 1a;

(2) bill the medical assistance program for personal care assistance services and qualified professional services;

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

(4) pay the personal care assistant and qualified professional based on actual hours of services provided;

(5) withhold and pay all applicable federal and state taxes;

(6) verify and keep records of hours worked by the personal care assistant and qualified professional;

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

Sec. 40. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency'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's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety 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 personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency'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 personal care assistance provider agency uses in the course of daily business including, but not limited to:

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

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section, including the requirements under subdivision 11, paragraph (d), if enhanced personal care assistance services are provided and submitted for an enhanced rate under subdivision 17a;

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

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

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the

agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies 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 before enrollment of the agency as a provider. 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 personal care assistance provider agency 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. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. 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. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 41. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;

(7) pay the personal care assistant and qualified professional based on actual hours of services provided;

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

(9) ~~effective January 1, 2010,~~ document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

(10) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(11) enter into a written agreement under subdivision 20 before services are provided;

(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;

(13) provide the recipient with a copy of the home care bill of rights at start of service; ~~and~~

(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner~~.~~;

(15) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a; and

(16) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements under subdivision 11, paragraph (d).

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 42. Minnesota Statutes 2018, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence, including verification of the completion of training required under subdivision 11, paragraph (d), if personal care assistance services eligible for the enhanced rate are provided and submitted for reimbursement under subdivision 17a;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 43. Minnesota Statutes 2018, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

(6) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on assessment and community support plan development,

appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

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

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

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

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

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

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

(ii) consumer support grants under section 256.476; or

(iii) section 256B.85;

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

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

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

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

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

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

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives. For the purposes of this section, "informed choice" means a voluntary choice of services by a person from all available service options based on accurate and complete information concerning all available service options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person to empower the person to make decisions.

Sec. 44. Minnesota Statutes 2018, section 256B.0911, subdivision 3a, is amended to read:

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

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment.

The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted in a face-to-face conversational interview with the person being assessed ~~and~~. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs ~~prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment~~ the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within ~~40 calendar days of the assessment visit~~ the timelines established by

the commissioner, regardless of whether the ~~individual~~ person is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under section 256B.0915, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

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

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers, including service provided in a non-disability-specific setting;

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

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

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

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

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and

living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

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

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

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

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

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated.

(k) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous face-to-face assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

(n) At the time of reassessment, the certified assessor shall assess each person receiving waiver services currently residing in a community residential setting, or licensed adult foster care home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23. The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

Sec. 45. Minnesota Statutes 2018, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** (a) Prior to a face-to-face reassessment, the certified assessor must review the person's most recent assessment. Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments ~~allow for~~ require a review of the most recent assessment, review of the current coordinated service and support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan. Reassessments verify continued eligibility or offer alternatives as warranted and provide an opportunity for quality assurance of service delivery. Face-to-face ~~assessments~~ reassessments must be conducted annually or as required by federal and state laws and rules. For reassessments, the certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person

receiving services and complete the updated community support plan and the updated coordinated service and support plan no more than 60 days from the reassessment visit.

(b) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

Sec. 46. Minnesota Statutes 2018, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3g. **Assessments for Rule 185 case management.** Unless otherwise required by federal law, the county agency is not required to conduct or arrange for an annual needs reassessment by a certified assessor. The case manager who works on behalf of the person to identify the person's needs and to minimize the impact of the disability on the person's life must instead develop a person-centered service plan based on the person's assessed needs and preferences. The person-centered service plan must be reviewed annually for persons with developmental disabilities who are receiving only case management services under Minnesota Rules, part 9525.0016, and who make an informed choice to decline an assessment under this section.

Sec. 47. Minnesota Statutes 2018, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes, including timelines for when assessments need to be completed, required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

(b) The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services to modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria.

(c) The commissioner shall work with lead agencies responsible for conducting long-term consultation services to develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency. The commissioner shall collect data on these benchmarks and provide to the lead agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over human services an annual trend analysis of

the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Sec. 48. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256R.17 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the monthly limit of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment. If a legislatively authorized increase is service-specific, the monthly cost limit shall be adjusted based on the overall average increase to the elderly waiver program.

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

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

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

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

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established

for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous December 31 shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on January 1 or since the previous January 1 and the average statewide percentage increase in nursing facility operating payment rates under chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on January 1, or occurring since the previous January 1.

(f) The commissioner shall approve an exception to the monthly case mix budget cap in paragraph (a) to account for the additional cost of providing enhanced rate personal care assistance services under section 256B.0659 or 256B.85. The exception shall not exceed 107.5 percent of the budget otherwise available to the individual. The exception must be reapproved on an annual basis at the time of a participant's annual reassessment.

EFFECTIVE DATE. This section is effective July 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 49. Minnesota Statutes 2018, section 256B.0915, subdivision 6, is amended to read:

Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly waiver client shall be provided a copy of a written coordinated service and support plan ~~which~~ that:

(1) is developed with and signed by the recipient within ~~ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (e);

(2) includes the person's need for service and identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person or the person's legal guardian or conservator;

(5) reflects the person's informed choice between institutional and community-based services, as well as choice of services, supports, and providers, including available case manager providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount, frequency, duration, and cost of the services to be provided to the person based on assessed needs, preferences, and available resources;

(8) includes information about the right to appeal decisions under section 256.045; and

(9) includes the authorized annual and estimated monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 50. Minnesota Statutes 2018, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan ~~which~~ that:

(1) is developed with and signed by the recipient within ~~ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (e);

(2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options and on services and supports to achieve employment goals;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The coordinated service and support plan shall also specify other services the person needs that are not available;

(8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

(10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

(11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 51. Minnesota Statutes 2018, section 256B.0921, is amended to read:

256B.0921 HOME AND COMMUNITY-BASED SERVICES ~~INCENTIVE~~ INNOVATION POOL.

The commissioner of human services shall develop an initiative to provide incentives for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated competitive employment for youth under age 25 upon their graduation from school; (3) living in the most integrated setting; and (4) other outcomes determined by the commissioner. The commissioner shall seek requests for proposals and shall contract with one or more entities to provide incentive payments for meeting identified outcomes.

Sec. 52. Minnesota Statutes 2018, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

(1) finalizing the written coordinated service and support plan within ~~ten working days after the case manager receives the plan from the certified assessor~~ the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (e);

(2) informing the recipient or the recipient's legal guardian or conservator of service options;

(3) assisting the recipient in the identification of potential service providers and available options for case management service and providers, including services provided in a non-disability-specific setting;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

Sec. 53. Minnesota Statutes 2018, section 256B.49, subdivision 14, is amended to read:

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

~~the finalization of the assessment or reassessment~~ who is familiar with the person. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

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

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

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

Sec. 54. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 1a. **Annual labor market reporting.** (a) As determined by the commissioner, a provider of home and community-based services for the elderly under sections 256B.0913 and 256B.0915, home and community-based services for people with developmental disabilities under section 256B.092, and home and community-based services for people with disabilities under section 256B.49 shall submit data to the commissioner on the following:

(1) number of direct-care staff;

(2) wages of direct-care staff;

(3) hours worked by direct-care staff;

(4) overtime wages of direct-care staff;

(5) overtime hours worked by direct-care staff;

(6) benefits paid and accrued by direct-care staff;

(7) direct-care staff retention rates;

(8) direct-care staff job vacancies;

(9) amount of travel time paid;

(10) program vacancy rates; and

(11) other related data requested by the commissioner.

(b) The commissioner may adjust reporting requirements for a self-employed direct-care staff.

(c) For the purposes of this subdivision, "direct-care staff" means employees, including self-employed individuals and individuals directly employed by a participant in a consumer-directed service delivery option, providing direct service provision to people receiving services under this section. Direct-care staff does not include executive, managerial, or administrative staff.

(d) This subdivision also applies to a provider of personal care assistance services under section 256B.0625, subdivision 19a; community first services and supports under section 256B.85; nursing services and home health services under section 256B.0625, subdivision 6a; home care nursing services under section 256B.0625, subdivision 7; or day training and habilitation services for residents of intermediate care facilities for persons with developmental disabilities under section 256B.501.

(e) This subdivision also applies to financial management services providers for participants who directly employ direct-care staff through consumer support grants under section 256.476; the personal care assistance choice program under section 256B.0657, subdivisions 18 to 20; community first services and supports under section 256B.85; and the consumer-directed community supports option available under the alternative care program, the brain injury waiver, the community alternative care waiver, the community access for disability inclusion waiver, the developmental disabilities waiver, the elderly waiver, and the Minnesota senior health option, except financial management services providers are not required to submit the data listed in paragraph (a), clauses (7) to (11).

(f) The commissioner shall ensure that data submitted under this subdivision is not duplicative of data submitted under any other section of this chapter or any other chapter.

(g) A provider shall submit the data annually on a date specified by the commissioner. The commissioner shall give a provider at least 30 calendar days to submit the data. If a provider fails to submit the requested data by the date specified by the commissioner, the commissioner may delay medical assistance reimbursement until the requested data is submitted.

(h) Individually identifiable data submitted to the commissioner in this section are considered private data on an individual, as defined by section 13.02, subdivision 12.

(i) The commissioner shall analyze data annually for workforce assessments and how the data impact service access.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 55. Minnesota Statutes 2018, section 256B.4913, subdivision 4a, is amended to read:

Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision, "implementation period" means the period beginning January 1, 2014, and ending on the last day of the month in which the rate management system is populated with the data necessary to calculate rates for substantially all individuals receiving home and community-based waiver services under sections 256B.092 and 256B.49. "Banding period" means the time period beginning on January 1, 2014, and ending upon the expiration of the 12-month period defined in paragraph (c), clause (5).

(b) For purposes of this subdivision, the historical rate for all service recipients means the individual reimbursement rate for a recipient in effect on December 1, 2013, except that:

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for the provider number in the county of service, effective December 1, 2013; or

(2) for a unit-based service with programming or a unit-based service without programming recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for each provider number in the county of service, effective December 1, 2013; or

(3) for residential service recipients who change providers on or after January 1, 2014, the historical rate must be set by each lead agency within their county aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the historical rate for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3);

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4); and

(6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately following the time period of clause (5). During this banding rate period, the commissioner shall not enforce any rate decrease or increase that would otherwise result from the end of the banding period. ~~The commissioner shall, upon enactment, seek federal approval for the addition of this banding period; and~~

~~(7) one percent from the rate in effect in clause (6) for the 12-month period immediately following the time period of clause (6).~~

(d) The commissioner shall review all changes to rates that were in effect on December 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service unit utilization on an annual basis as those in effect on October 31, 2013.

(e) By December 31, 2014, the commissioner shall complete the review in paragraph (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

(f) During the banding period, the Medicaid Management Information System (MMIS) service agreement rate must be adjusted to account for change in an individual's need. The commissioner shall adjust the Medicaid Management Information System (MMIS) service agreement rate by:

(1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the level of service in effect on December 1, 2013;

(2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the updated level of service at the time of application; and

(3) adding to or subtracting from the Medicaid Management Information System (MMIS) service agreement rate, the difference between the values in clauses (1) and (2).

(g) This subdivision must not apply to rates for recipients served by providers new to a given county after January 1, 2014. Providers of personal supports services who also acted as fiscal support entities must be treated as new providers as of January 1, 2014.

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

Sec. 56. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Comparable occupations" means the occupations, excluding direct care staff, as represented by the Bureau of Labor Statistics standard occupational classification codes that have the same classification for:

(1) typical education needed for entry;

(2) work experience in a related occupation; and

(3) typical on-the-job training competency as the most predominant classification for direct care staff.

~~(c)~~ (d) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

~~(d)~~ (e) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(f) "Direct care staff" means employees providing direct service to people receiving services under this section. Direct care staff excludes executive, managerial, and administrative staff.

~~(e)~~ (g) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

~~(f)~~ (h) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section

245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

~~(g)~~ (i) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

~~(h)~~ (j) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

~~(i)~~ (k) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

~~(j)~~ (l) "Rates management system" means a web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

~~(k)~~ (m) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

~~(l)~~ (n) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

~~(m)~~ (o) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

~~(n)~~ (p) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for day support services, a unit of service is 15 minutes; and

~~(iii)~~ (iv) for prevocational services, a unit of service is a day or ~~an hour~~ 15 minutes. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9, a unit of service is 15 minutes.

Sec. 57. Minnesota Statutes 2018, section 256B.4914, subdivision 3, as amended by Laws 2019, chapter 50, article 2, section 1, is amended to read:

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day ~~care~~ services;

(3) adult day ~~care~~ services bath;

~~(4) behavioral programming;~~

~~(5)~~ (4) companion services;

(5) community residential services;

(6) customized living;

(7) day support services;

~~(7)~~ (8) day training and habilitation;

(9) employment development services;

(10) employment exploration services;

(11) employment support services;

(12) family residential services;

~~(8)~~ (13) housing access coordination;

~~(9)~~ (14) independent living skills;

(15) individualized home supports;

(16) individualized home supports with family training;

(17) individualized home supports with training;

~~(10)~~ (18) in-home family support;

(19) integrated community supports;

~~(11)~~ (20) night supervision;

~~(12)~~ (21) personal support;

(22) positive support services;

~~(13)~~ (23) prevocational services;

~~(14) residential care services;~~

~~(15)~~ (24) residential support services;

~~(16)~~ (25) respite services;

~~(17)~~ (26) structured day services;

~~(18)~~ (27) supported living services;

~~(19)~~ (28) transportation services; and

~~(20) individualized home supports;~~

~~(21) independent living skills specialist services;~~

~~(22) employment exploration services;~~

~~(23) employment development services;~~

~~(24) employment support services; and~~

~~(25)~~ (29) other services as approved by the federal government in the state home and community-based services plan.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 58. Minnesota Statutes 2018, section 256B.4914, subdivision 4, is amended to read:

Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and community-based waivered services, including rate exceptions under subdivision 12, are set by the rates management system.

~~(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a manner prescribed by the commissioner.~~

~~(c)~~ (b) Data and information in the rates management system may be used to calculate an individual's rate.

~~(d)~~ (c) Service providers, with information from the community support plan and oversight by lead agencies, shall provide values and information needed to calculate an individual's rate into the rates management system. The determination of service levels must be part of a discussion with members of the support team as defined in section 245D.02, subdivision 34. This discussion must occur prior to the final establishment of each individual's rate. The values and information include:

(1) shared staffing hours;

(2) individual staffing hours;

(3) direct registered nurse hours;

(4) direct licensed practical nurse hours;

(5) staffing ratios;

(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;

(7) shared or individualized arrangements for unit-based services, including the staffing ratio;

(8) number of trips and miles for transportation services; and

(9) service hours provided through monitoring technology.

~~(e)~~ (d) Updates to individual data must include:

(1) data for each individual that is updated annually when renewing service plans; and

(2) requests by individuals or lead agencies to update a rate whenever there is a change in an individual's service needs, with accompanying documentation.

~~(f)~~ (e) Lead agencies shall review and approve all services reflecting each individual's needs, and the values to calculate the final payment rate for services with variables under subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and the service provider of the final agreed-upon values and rate, and provide information that is identical to what was entered into the rates management system. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead agencies to correct it. Lead agencies must respond to these requests. When responding to the request, the lead agency must consider:

(1) meeting the health and welfare needs of the individual or individuals receiving services by service site, identified in their coordinated service and support plan under section 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

(2) meeting the requirements for staffing under subdivision 2, paragraphs ~~(f)~~ (h), ~~(i)~~ (n), and ~~(m)~~ (o); and meeting or exceeding the licensing standards for staffing required under section 245D.09, subdivision 1; and

(3) meeting the staffing ratio requirements under subdivision 2, paragraph ~~(n)~~ (o), and meeting or exceeding the licensing standards for staffing required under section 245D.31.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 59. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in

the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for adult day services, 70 percent of the median wage for nursing assistant (SOC code 31-1014); and 30 percent of the median wage for personal care aide (SOC code 39-9021);

~~(2)~~ (3) for day services, day support services, and prevocational services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(3)~~ (4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

~~(4)~~ (5) for ~~behavior program~~ positive supports analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

~~(5)~~ (6) for ~~behavior program~~ positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

~~(6)~~ (7) for ~~behavior program~~ positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

~~(7)~~ (8) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(8)~~ (9) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(9)~~ (10) for in-home family support and individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

~~(10)~~ (11) for individualized home supports with training services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

~~(11)~~ (12) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

~~(12) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);~~

~~(13) for supported employment staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);~~

~~(14)~~ (13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(15)~~ (14) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(16)~~ (15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of ~~behavior~~ positive supports professional, ~~behavior~~ positive supports analyst, and ~~behavior~~ positive supports specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for ~~residential~~ corporate foster care services, corporate supportive living services daily, community residential services, and integrated community support services are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) general administrative support ratio: 13.25 percent;

~~(5)~~ (6) program-related expense ratio: 1.3 percent; and

~~(6)~~ (7) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) general administrative support ratio: 3.3 percent;

~~(5)~~ (6) program-related expense ratio: 1.3 percent; and

~~(6)~~ (7) absence factor: 1.7 percent.

(d) Component values for day ~~services for all services~~ training and habilitation, day support services, and prevocational services are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) program plan support ratio: 5.6 percent;

~~(5)~~ (6) client programming and support ratio: ten percent;

~~(6)~~ (7) general administrative support ratio: 13.25 percent;

~~(7)~~ (8) program-related expense ratio: 1.8 percent; and

~~(8)~~ (9) absence and utilization factor ratio: 9.4 percent.

(e) Component values for adult day services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

~~(e)~~ (f) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) program plan supports ratio: 15.5 percent;

~~(5)~~ (6) client programming and supports ratio: 4.7 percent;

~~(6)~~ (7) general administrative support ratio: 13.25 percent;

~~(7)~~ (8) program-related expense ratio: 6.1 percent; and

~~(8)~~ (9) absence and utilization factor ratio: 3.9 percent.

~~(f)~~ (g) Component values for unit-based services without programming except respite are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) program plan support ratio: 7.0 percent;

~~(5)~~ (6) client programming and support ratio: 2.3 percent;

~~(6)~~ (7) general administrative support ratio: 13.25 percent;

~~(7)~~ (8) program-related expense ratio: 2.9 percent; and

~~(8)~~ (9) absence and utilization factor ratio: 3.9 percent.

~~(g)~~ (h) Component values for unit-based services without programming for respite are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) general administrative support ratio: 13.25 percent;

~~(5)~~ (6) program-related expense ratio: 2.9 percent; and

~~(6)~~ (7) absence and utilization factor ratio: 3.9 percent.

~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system.~~ (i) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on ~~the most recently available~~ wage data by SOC from the Bureau of Labor Statistics available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(j) Beginning February 1, 2021, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor. The report must include recommendations to update the competitive workforce factor using:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential services and direct care staff for day services;

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and

(3) workforce data as required under subdivision 10a, paragraph (g).

The commissioner shall not recommend an increase or decrease of the competitive workforce factor from the current value by more than two percentage points. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

~~(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system.~~ (k) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the framework components in paragraph (d), clause ~~(5)~~ (6); paragraph (e), clause (6); paragraph ~~(e)~~ (f), clause ~~(5)~~ (6); and paragraph ~~(f)~~ (g), clause ~~(5)~~ (6); subdivision 6, paragraphs (b), clauses ~~(8)~~ (9) and ~~(9)~~ (10), and (e), clause (10); and subdivision 7, clauses ~~(10)~~ (11), ~~(16)~~ (17), and ~~(17)~~ (18), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the ~~date of the~~ data ~~most recently~~ available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(l) Upon the implementation of the updates under paragraphs (i) and (k), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

(m) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of the updates under paragraphs (i) and (k).

~~(j)~~ (n) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, except:

(1) paragraph (b), clause (1); paragraph (c), clause (1); paragraph (d), clause (1); paragraph (f), clause (1); paragraph (g), clause (1); and paragraph (h), clause (1), are effective January 1, 2020, or upon federal approval, whichever is later;

(2) paragraphs (i) and (k) are effective July 1, 2022, or upon federal approval, whichever is later; and

(3) paragraph (l) is effective retroactively from July 1, 2018.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 60. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) ~~Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:~~ For purposes of this subdivision, residential support services includes 24-hour customized living services, community residential services, customized living services, family residential services, foster care services, integrated community supports, and supportive living services daily.

(b) Payments for community residential services, corporate foster care services, corporate supportive living services daily, family residential services, and family foster care services must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

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

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct-care rate~~;

~~(4)~~ (5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages ~~in subdivision 5, paragraph (a), or the customized direct-care rate~~;

~~(5)~~ (6) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the

result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause ~~(2)~~ (3). This is defined as the direct staffing cost;

~~(7)~~ (8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause ~~(3)~~ (4);

~~(8)~~ (9) for client programming and supports, the commissioner shall add $2,179; and

~~(9)~~ (10) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

~~(b)~~ (c) The total rate must be calculated using the following steps:

(1) subtotal paragraph ~~(a)~~ (b), clauses ~~(7) to (9)~~ (8) to (10), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause ~~(7)~~ (8);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

~~(c)~~ (d) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs.

(e) Payments for integrated community support services must be calculated as follows:

(1) the base shared staffing shall be eight hours divided by the number of people receiving support in the integrated community support setting;

(2) the individual staffing hours shall be the average number of direct support hours provided directly to the service recipient;

(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(4) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (3) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(5) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (4);

(6) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the appropriate staff wages;

(7) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause (21);

(8) combine the results of clauses (6) and (7) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(9) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

(10) for client programming and supports, the commissioner shall add $2,260.21 divided by 365.

(f) The total rate must be calculated as follows:

(1) add the results of paragraph (e), clauses (9) and (10);

(2) add the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(g) The payment methodology for customized living and 24-hour customized living services must be the customized living tool. The commissioner shall revise the customized living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.

~~(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must meet or exceed the days of service used to convert service agreements in effect on December 1, 2013, and must not result in a reduction in spending or service utilization due to conversion during the implementation period under section 256B.4913, subdivision 4a. If during the implementation period, an individual's historical rate, including adjustments required under section 256B.4913, subdivision 4a, paragraph (e), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.~~

~~(e)~~ (h) The number of days authorized for all individuals enrolling ~~after January 1, 2014,~~ in residential services must include every day that services start and end.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later, except paragraphs (e) to (g) are effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 61. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day ~~care~~ services, day treatment and habilitation, day support services, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (d), clause (1);

~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct-care rate~~;

~~(4)~~ (5) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage ~~in subdivision 5, paragraph (a), or the customized direct-care rate~~;

~~(5)~~ (6) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause ~~(4)~~ (5);

~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause ~~(3)~~ (4);

~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause ~~(5)~~ (6);

~~(10)~~ (11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

~~(11)~~ (12) for adult day bath services, add $7.01 per 15 minute unit;

~~(12)~~ (13) this is the subtotal rate;

~~(13)~~ (14) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

~~(14)~~ (15) divide the result of clause ~~(12)~~ (13) by one minus the result of clause ~~(13)~~ (14). This is the total payment amount;

~~(15)~~ (16) adjust the result of clause ~~(14)~~ (15) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

~~(16)~~ (17) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

~~(17)~~ (18) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later, except the service name changes are effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 62. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including ~~behavior programming~~ employment exploration services, employment development services, housing access coordination, individualized home supports with family training, individualized home supports with training, in-home family support, independent living skills training, ~~independent living skills specialist services, individualized home supports, hourly supported living services, employment exploration services, employment development services, supported employment, and employment support~~ and hourly supported living services provided to an individual outside of any day

or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

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

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (f), clause (1);

~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct-care rate~~;

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

~~(5)~~ (6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(e)~~ (f), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(e)~~ (f), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the program plan supports ratio in subdivision 5, paragraph ~~(e)~~ (f), clause ~~(4)~~ (5);

~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(e)~~ (f), clause ~~(3)~~ (4);

~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by one plus the client programming and supports ratio in subdivision 5, paragraph ~~(e)~~ (f), clause ~~(5)~~ (6);

~~(10)~~ (11) this is the subtotal rate;

~~(11)~~ (12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

~~(12)~~ (13) divide the result of clause ~~(10)~~ (11) by one minus the result of clause ~~(11)~~ (12). This is the total payment amount;

~~(13)~~ (14) for ~~supported~~ employment exploration services provided in a shared manner, divide the total payment amount in clause ~~(12)~~ (13) by the number of service recipients, not to exceed ~~three~~ five. For employment support services provided in a shared manner, divide the total payment amount in clause ~~(12)~~ (13) by the number of service recipients, not to exceed six. For independent living skills training ~~and~~, individualized home supports with training, and individualized home supports with family training provided in a shared manner, divide the total payment amount in clause ~~(12)~~ (13) by the number of service recipients, not to exceed two; and

~~(14)~~ (15) adjust the result of clause ~~(13)~~ (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 63. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including individualized home supports, night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (g), clause (1);

~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct care rate~~;

~~(4)~~ (5) multiply the number of direct staff hours by the appropriate staff wage ~~in subdivision 5 or the customized direct care rate~~;

~~(5)~~ (6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(f)~~ (g), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(f)~~ (g), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the program plan support ratio in subdivision 5, paragraph ~~(f)~~ (g), clause ~~(4)~~ (5);

~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(f)~~ (g), clause ~~(3)~~ (4);

~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(f)~~ (g), clause ~~(5)~~ (6);

~~(10)~~ (11) this is the subtotal rate;

~~(11)~~ (12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

~~(12)~~ (13) divide the result of clause ~~(10)~~ (11) by one minus the result of clause ~~(11)~~ (12). This is the total payment amount;

~~(13)~~ (14) for respite services, determine the number of day units of service to meet an individual's needs;

~~(14)~~ (15) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (15) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (h), clause (1);

~~(15)~~ (17) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(14)~~ (16)~~. This is defined as the customized direct care rate~~;

~~(16)~~ (18) multiply the number of direct staff hours by the appropriate staff wage ~~in subdivision 5, paragraph (a)~~;

~~(17)~~ (19) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph ~~(g)~~ (h), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(18)~~ (20) combine the results of clauses ~~(16)~~ (18) and ~~(17)~~ (19), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (h), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

~~(19)~~ (21) for employee-related expenses, multiply the result of clause ~~(18)~~ (20) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (h), clause ~~(3)~~ (4);

~~(20)~~ (22) this is the subtotal rate;

~~(21)~~ (23) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

~~(22)~~ (24) divide the result of clause ~~(20)~~ (22) by one minus the result of clause ~~(21)~~ (23). This is the total payment amount; ~~and~~

(25) for individualized home supports provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two;

(26) for respite care services provided in a shared manner, divide the total payment amount in clause (24) by the number of service recipients, not to exceed three; and

~~(23)~~ (27) adjust the result of clauses ~~(12) and (22)~~ (13), (25), and (26) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later, except the service name change is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 64. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** ~~(a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.~~

~~(b) No later than July 1, 2014,~~ (a) The commissioner shall, within available resources, ~~begin to~~ conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

~~(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014, and the final report shall be issued by December 31, 2018.~~

~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates;

(2) values for services where monitoring technology replaces staff time;

(3) values for indirect services;

(4) values for nursing;

(5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

(6) values for workers' compensation as part of employee-related expenses;

(7) values for unemployment insurance as part of employee-related expenses;

(8) direct care workforce labor market measures;

(9) any changes in state or federal law with a direct impact on the underlying cost of providing home and community-based services; ~~and~~

~~(9)~~ (10) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section~~.~~; and

(11) different competitive workforce factors by service, as determined under subdivision 5, paragraph (j).

~~(e)~~ (c) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs ~~(b) to (d)~~ (a) and (b) on ~~the following dates:~~

~~(1) January 15, 2015, with preliminary results and data;~~

~~(2) January 15, 2016, with a status implementation update, and additional data and summary information;~~

~~(3) January 15, 2017, with the full report; and~~

~~(4)~~ January 15, ~~2020~~ 2021, with ~~another~~ a full report, and a full report once every four years thereafter.

~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning ~~July 1, 2017~~ July 1, 2022, the commissioner shall renew analysis and implement changes to the regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h), occur~~ once every six years. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

~~(g)~~ (e) The commissioner shall provide a public notice via LISTSERV in October of each year ~~beginning October 1, 2014,~~ containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

~~(h)~~ (f) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, ~~or insufficient to meet the needs of an individual with a service agreement adjustment~~

~~described in section 256B.4913, subdivision 4a, paragraph (f),~~ then individual staffing hours shall be used.

~~(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph, the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.~~

~~(j) Beginning July 1, 2017,~~ (g) The commissioner shall collect transportation and trip information for all day services through the rates management system.

(h) The commissioner, in consultation with stakeholders, shall study value-based models and outcome-based payment strategies for fee-for-service home and community-based services and report to the legislative committees with jurisdiction over the disability waiver rate system by October 1, 2020, with recommended strategies to: (1) promote new models of care, services, and reimbursement structures that require more efficient use of public dollars while improving the outcomes most valued by the individuals served; (2) assist clients and their families in evaluating options and stretching individual budget funds; (3) support individualized, person-centered planning and individual budget choices; and (4) create a broader range of client options geographically or targeted at culturally competent models for racial and ethnic minority groups.

EFFECTIVE DATE. This section is effective the day following final enactment, except the amendment to paragraph (f) is effective January 1, 2020.

Sec. 65. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in ~~section 256B.4913,~~ subdivision ~~5~~ 17, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders identified in ~~section 256B.4913,~~ subdivision ~~5~~ 17, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, ~~2020~~ 2021. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph ~~(e)~~ (c). The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(e) The commissioner, in consultation with stakeholders identified in ~~section 256B.4913,~~ subdivision ~~5~~ 17, shall develop and implement a process for providing training and technical

assistance necessary to support provider submission of cost documentation required under paragraph (a).

(f) By December 31, 2020, providers paid with rates calculated under subdivision 5, paragraph (b), shall identify additional revenues from the competitive workforce factor and prepare a written distribution plan for the revenues. A provider shall make the provider's distribution plan available and accessible to all direct care staff for a minimum of one calendar year. Upon request, a provider shall submit the written distribution plan to the commissioner.

(g) Providers enrolled to provide services with rates determined under section 256B.4914, subdivision 3, shall submit labor market data to the commissioner annually on or before November 1, including but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) overtime wages of direct care staff;

(4) hours worked by direct care staff;

(5) overtime hours worked by direct care staff;

(6) benefits provided to direct care staff;

(7) direct care staff job vacancies; and

(8) direct care staff retention rates.

(h) The commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data obtained under paragraph (g).

(i) The commissioner may temporarily suspend payments to the provider if data requested under paragraph (g) is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(j) Providers who receive payment under this section for less than 25 percent of their clients in the year prior to the report may attest to the commissioner in a manner determined by the commissioner that they are declining to provide the data required under paragraph (g) and will not be subject to the payment suspension in paragraph (i).

EFFECTIVE DATE. This section is effective the day following final enactment except paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1, 2020.

Sec. 66. Minnesota Statutes 2018, section 256B.4914, subdivision 14, is amended to read:

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

(b) Lead agencies must act on an exception request within 30 days and notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the commissioner.

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

(1) an individual has service needs that cannot be met through additional units of service;

(2) an individual's rate determined under subdivisions 6, 7, 8, and 9 is so insufficient that it has resulted in an individual receiving a notice of discharge from the individual's provider; or

(3) an individual's service needs, including behavioral changes, require a level of service which necessitates a change in provider or which requires the current provider to propose service changes beyond those currently authorized.

(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6, 7, 8, and 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6, 7, 8, and 9;

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation; and

(4) any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients, an interested party, or the license holder that would receive the rate exception increase may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient,

interested party, or license holder of its decision and the reasons for denying the request in writing no later than 30 days after the request has been made and shall submit its denial to the commissioner in accordance with paragraph (b). The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient, the interested party, and the license holder in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

(j) The starting date for the rate exception will be the later of the date of the recipient's change in support or the date of the request to the lead agency for an exception.

(k) The commissioner shall track all exception requests received and their dispositions. The commissioner shall issue quarterly public exceptions statistical reports, including the number of exception requests received and the numbers granted, denied, withdrawn, and pending. The report shall include the average amount of time required to process exceptions.

~~(l) No later than January 15, 2016, the commissioner shall provide research findings on the estimated fiscal impact, the primary cost drivers, and common population characteristics of recipients with needs that cannot be met by the framework rates.~~

~~(m) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a process to determine eligibility for rate exceptions for individuals with rates determined under the methodology in section 256B.4913, subdivision 4a. Determination of eligibility for an exception will occur as annual service renewals are completed.~~

~~(n)~~ (l) Approved rate exceptions ~~will be implemented at such time that the individual's rate is no longer banded and~~ remain in effect in all cases until an individual's needs change as defined in paragraph (c).

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 67. Minnesota Statutes 2018, section 256B.4914, subdivision 15, is amended to read:

Subd. 15. **County or tribal allocations.** (a) ~~Upon implementation of the disability waiver rates management system on January 1, 2014,~~ The commissioner shall establish a method of tracking and reporting the fiscal impact of the disability waiver rates management system on individual lead agencies.

(b) ~~Beginning January 1, 2014,~~ The commissioner shall make annual adjustments to lead agencies' home and community-based waivered service budget allocations to adjust for rate differences and the resulting impact on county allocations upon implementation of the disability waiver rates system.

(c) Lead agencies exceeding their allocations shall be subject to the provisions under sections 256B.0916, subdivision 11, and 256B.49, subdivision 26.

Sec. 68. Minnesota Statutes 2018, section 256B.4914, is amended by adding a subdivision to read:

Subd. 17. **Stakeholder consultation and county training.** (a) The commissioner shall continue consultation at regular intervals with the existing stakeholder group established as part of the rate-setting methodology process and others, to gather input, concerns, and data, to assist in the implementation of the rate payment system, and to make pertinent information available to the public through the department's website.

(b) The commissioner shall offer training at least annually for county personnel responsible for administering the rate-setting framework in a manner consistent with this section.

(c) The commissioner shall maintain an online instruction manual explaining the rate-setting framework. The manual shall be consistent with this section, and shall be accessible to all stakeholders including recipients, representatives of recipients, county or tribal agencies, and license holders.

(d) The commissioner shall not defer to the county or tribal agency on matters of technical application of the rate-setting framework, and a county or tribal agency shall not set rates in a manner that conflicts with this section.

Sec. 69. Minnesota Statutes 2018, section 256B.5014, is amended to read:

256B.5014 ~~FINANCIAL~~ REPORTING REQUIREMENTS.

Subdivision 1. **Financial reporting.** All facilities shall maintain financial records and shall provide annual income and expense reports to the commissioner of human services on a form prescribed by the commissioner no later than April 30 of each year in order to receive medical assistance payments. The reports for the reporting year ending December 31 must include:

(1) salaries and related expenses, including program salaries, administrative salaries, other salaries, payroll taxes, and fringe benefits;

(2) general operating expenses, including supplies, training, repairs, purchased services and consultants, utilities, food, licenses and fees, real estate taxes, insurance, and working capital interest;

(3) property related costs, including depreciation, capital debt interest, rent, and leases; and

(4) total annual resident days.

Subd. 2. **Labor market reporting.** All intermediate care facilities shall comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a.

Sec. 70. Minnesota Statutes 2018, 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 an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

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

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

(4) has medical services identified in a person'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 participant under a family support grant under section 252.32.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

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

Sec. 71. Minnesota Statutes 2018, section 256B.85, is amended by adding a subdivision to read:

Subd. 7a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for 12 or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e). The enhanced rate for CFSS includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2019, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54 that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of CFSS per day.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 72. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a) Agency-providers identified in subdivision 11 and FMS providers identified in subdivision 13a shall:

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

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

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

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

(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; and

(9) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS providers shall:

(1) pay support workers 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;

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

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

(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;

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

(7) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a;

~~(7)~~ (8) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13~~.~~; and

(9) maintain documentation for the requirements under subdivision 16, paragraph (e), clause (2), to qualify for an enhanced rate under this section.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 73. Minnesota Statutes 2018, section 256B.85, subdivision 11, is amended to read:

Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services provided by support workers and staff providing worker training and development services who are employed by an agency-provider that meets the 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 CFSS service delivery plan.

(c) A participant may use authorized units of CFSS services as needed within a service agreement 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 CFSS 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, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by individuals who are 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 CFSS service delivery plan and detailed budget for expenditures that must be approved by the consultation services provider, case manager, or care coordinator; and

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

Sec. 74. Minnesota Statutes 2018, section 256B.85, subdivision 12, is amended to read:

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

(1) the CFSS 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 agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety 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 agency-provider's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors and owners to other service providers;

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

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

(i) a copy of the CFSS agency-provider's time sheet; and

(ii) a copy of the participant's individual CFSS service delivery plan;

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

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

(11) documentation of the 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-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except 100 percent of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services shall not be used in making this calculation; and

(14) documentation that the agency-provider does not burden participants' free exercise of their right to choose service providers by requiring CFSS support workers to sign an agreement not to work with any particular CFSS participant or for another CFSS 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 agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS 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 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 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.

(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 all required documentation for annual review within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

Sec. 75. Minnesota Statutes 2018, 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 the support worker:

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

(ii) is disqualified, but 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 participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) complete the basic standardized CFSS 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. CFSS 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;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

(7) 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) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the 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 by 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.

(e) CFSS qualify for an enhanced rate if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for 12 or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 76. Minnesota Statutes 2018, section 256I.03, subdivision 8, is amended to read:

Subd. 8. **Supplementary services.** "Supplementary services" means housing support services provided to individuals in addition to room and board including, but not limited to, oversight and up to 24-hour supervision, medication reminders, assistance with

transportation, arranging for meetings and appointments, and arranging for medical and social services, and services identified in section 256I.03, subdivision 12.

Sec. 77. Minnesota Statutes 2018, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers of housing support must be in writing on a form developed and approved by the commissioner and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from housing support funds for each eligible resident at each location; the number of beds at each location which are subject to the agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

(b) Providers are required to verify the following minimum requirements in the agreement:

(1) current license or registration, including authorization if managing or monitoring medications;

(2) all staff who have direct contact with recipients meet the staff qualifications;

(3) the provision of housing support;

(4) the provision of supplementary services, if applicable;

(5) reports of adverse events, including recipient death or serious injury; ~~and~~

(6) submission of residency requirements that could result in recipient eviction~~.~~; and

(7) confirmation that the provider will not limit or restrict the number of hours an applicant or recipient chooses to be employed, as specified in subdivision 5.

(c) Agreements may be terminated with or without cause by the commissioner, the agency, or the provider with two calendar months prior notice. The commissioner may immediately terminate an agreement under subdivision 2d.

Sec. 78. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision to read:

Subd. 2h. **Required supplementary services.** Providers of supplementary services shall ensure that recipients have, at a minimum, assistance with services as identified in the recipient's professional statement of need under section 256I.03, subdivision 12. Providers of supplementary services shall maintain case notes with the date and description of services provided to individual recipients.

Sec. 79. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision to read:

Subd. 5. **Employment.** A provider is prohibited from limiting or restricting the number of hours an applicant or recipient is employed.

Sec. 80. Laws 2017, First Special Session chapter 6, article 1, section 44, is amended to read:

Sec. 44. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, 2017, if necessary, the commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to expand the exception to the consumer-directed community supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide up to 30 percent more funds for either:

(1) consumer-directed community supports participants who have a coordinated service and support plan which identifies the need for an increased amount of services or supports under consumer-directed community supports than the amount they are currently receiving under the consumer-directed community supports budget methodology:

(i) to increase the amount of time a person works or otherwise improves employment opportunities;

(ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes, section 256D.44, subdivision 5, ~~paragraph (f), clause (1), item (ii), or~~ paragraph (g), clause (1), item (iii); or

(iii) to develop and implement a positive behavior support plan; or

(2) home and community-based waiver participants who are currently using licensed providers for (i) employment supports or services during the day; or (ii) residential services, either of which cost more annually than the person would spend under a consumer-directed community supports plan for any or all of the supports needed to meet the goals identified in paragraph (a), clause (1), items (i), (ii), and (iii).

(b) The exception under paragraph (a), clause (1), is limited to those persons who can demonstrate that they will have to discontinue using consumer-directed community supports and accept other non-self-directed waiver services because their supports needed for the goals described in paragraph (a), clause (1), items (i), (ii), and (iii), cannot be met within the consumer-directed community supports budget limits.

(c) The exception under paragraph (a), clause (2), is limited to those persons who can demonstrate that, upon choosing to become a consumer-directed community supports participant, the total cost of services, including the exception, will be less than the cost of current waiver services.

Sec. 81. Laws 2017, First Special Session chapter 6, article 1, section 45, is amended to read:

Sec. 45. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY ~~EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND CRISIS RESIDENTIAL SETTINGS~~.**

Subdivision 1. **Exception for persons leaving institutions and crisis residential settings.** (a) By September 30, 2017, the commissioner shall establish an institutional and crisis bed consumer-directed community supports budget exception process in the home and community-based services waivers under Minnesota Statutes, sections 256B.092 and 256B.49. This budget exception process shall be available for any individual who:

(1) is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; and

(2) requires services that are more expensive than appropriate services provided in a noninstitutional setting using the consumer-directed community supports option.

(b) Institutional settings for purposes of this exception include intermediate care facilities for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget exception shall be limited to no more than the amount of appropriate services provided in

a noninstitutional setting as determined by the lead agency managing the individual's home and community-based services waiver. The lead agency shall notify the Department of Human Services of the budget exception.

Subd. 2. **Shared services.** (a) Medical assistance payments for shared services under consumer-directed community supports are limited to this subdivision.

(b) For purposes of this subdivision, "shared services" means services provided at the same time by the same direct care worker for individuals who have entered into an agreement to share consumer-directed community support services.

(c) Shared services may include services in the personal assistance category as outlined in the consumer-directed community supports community support plan and shared services agreement, except:

(1) services for more than three individuals provided by one worker at one time;

(2) use of more than one worker for the shared services; and

(3) a child care program licensed under chapter 245A or operated by a local school district or private school.

(d) The individuals or, as needed, their representatives shall develop the plan for shared services when developing or amending the consumer-directed community supports plan, and must follow the consumer-directed community supports process for approval of the plan by the lead agency. The plan for shared services in an individual's consumer-directed community supports plan shall include the intention to utilize shared services based on individuals' needs and preferences.

(e) Individuals sharing services must use the same financial management services provider.

(f) Individuals whose consumer-directed community supports community support plans include the intention to utilize shared services must also jointly develop, with the support of their representatives as needed, a shared services agreement. This agreement must include:

(1) the names of the individuals receiving shared services;

(2) the individuals' representative, if identified in their consumer-directed community supports plans, and their duties;

(3) the names of the case managers;

(4) the financial management services provider;

(5) the shared services that must be provided;

(6) the schedule for shared services;

(7) the location where shared services must be provided;

(8) the training specific to each individual served;

(9) the training specific to providing shared services to the individuals identified in the agreement;

(10) instructions to follow all required documentation for time and services provided;

(11) a contingency plan for each of the individuals that accounts for service provision and billing in the absence of one of the individuals in a shared services setting due to illness or other circumstances;

(12) signatures of all parties involved in the shared services; and

(13) agreement by each of the individuals who are sharing services on the number of shared hours for services provided.

(g) Any individual or any individual's representative may withdraw from participating in a shared services agreement at any time.

(h) The lead agency for each individual must authorize the use of the shared services option based on the criteria that the shared service is appropriate to meet the needs, health, and safety of each individual for whom they provide case management or care coordination.

(i) Nothing in this subdivision must be construed to reduce the total authorized consumer-directed community supports budget for an individual.

(j) No later than September 30, 2019, the commissioner of human services shall:

(1) submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49, to allow for a shared services option under consumer-directed community supports; and

(2) with stakeholder input, develop guidance for shared services in consumer-directed community-supports within the Community Based Services Manual. Guidance must include:

(i) recommendations for negotiating payment for one-to-two and one-to-three services; and

(ii) a template of the shared services agreement.

EFFECTIVE DATE. This section is effective October 1, 2019, or upon federal approval, whichever is later, except for subdivision 2, paragraph (j), which is effective the day following final enactment. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 82. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to read:

Sec. 49. **ELECTRONIC ~~SERVICE DELIVERY DOCUMENTATION SYSTEM~~ VISIT VERIFICATION.**

Subdivision 1. **Documentation; establishment.** The commissioner of human services shall establish implementation requirements and standards for ~~an~~ electronic ~~service delivery documentation system~~ visit verification to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

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

(b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic documentation of the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(c) "Electronic ~~service delivery documentation~~ visit verification system" means a system that provides electronic ~~service delivery documentation~~ verification of services that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(d) "Service" means one of the following:

(1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625, subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

(2) community first services and supports under Minnesota Statutes, section 256B.85;

(3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a; or

(4) other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

Subd. 3. **Requirements.** (a) In developing implementation requirements for ~~an~~ electronic ~~service delivery documentation system~~ visit verification, the commissioner shall ~~consider electronic visit verification systems and other electronic service delivery documentation methods. The commissioner shall convene stakeholders that will be impacted by an electronic service delivery system, including service providers and their representatives, service recipients and their representatives, and, as appropriate, those with expertise in the development and operation of an electronic service delivery documentation system, to~~ ensure that the requirements:

(1) are minimally administratively and financially burdensome to a provider;

(2) are minimally burdensome to the service recipient and the least disruptive to the service recipient in receiving and maintaining allowed services;

(3) consider existing best practices and use of electronic ~~service delivery documentation~~ visit verification;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner shall make training available to providers on the electronic ~~service delivery documentation~~ visit verification system requirements.

(c) The commissioner shall establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic ~~service delivery documentation~~ visit verification requirements on program integrity.

(d) The commissioner shall make a state-selected electronic visit verification system available to providers of services.

Subd. 3a. **Provider requirements.** (a) A provider of services may select any electronic visit verification system that meets the requirements established by the commissioner.

(b) All electronic visit verification systems used by providers to comply with the requirements established by the commissioner must provide data to the commissioner in a format and at a frequency to be established by the commissioner.

(c) Providers must implement the electronic visit verification systems required under this section by a date established by the commissioner to be set after the state-selected electronic visit verification systems for personal care services and home health services are in production. For purposes of this paragraph, "personal care services" and "home health services" have the meanings given in United States Code, title 42, section 1396b(l)(5). Reimbursement rates for providers must not be reduced as a result of federal action to reduce the federal medical assistance percentage under the 21st Century Cures Act, Public Law 114-255.

~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services with recommendations, based on the requirements of subdivision 3, to establish electronic service delivery documentation system requirements and standards. The report shall identify:~~

~~(1) the essential elements necessary to operationalize a base-level electronic service delivery documentation system to be implemented by January 1, 2019; and~~

~~(2) enhancements to the base-level electronic service delivery documentation system to be implemented by January 1, 2019, or after, with projected operational costs and the costs and benefits for system enhancements.~~

~~(b) The report must also identify current regulations on service providers that are either inefficient, minimally effective, or will be unnecessary with the implementation of an electronic service delivery documentation system.~~

Sec. 83. **INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

The labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota, submitted to the Legislative Coordinating Commission on March 11, 2019, is ratified.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 84. **RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS WORKFORCE NEGOTIATIONS.**

(a) Effective July 1, 2019, if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner of human services shall:

(1) increase reimbursement rates, individual budgets, grants, or allocations by 2.37 percent for services provided on or after July 1, 2019, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement; and

(2) for services provided on or after July 1, 2019, to eligible service recipients, provide an enhanced rate of 7.5 percent for personal care assistance and community first services and supports and an enhanced budget increased by 7.5 percent for consumer-directed community supports and the consumer support grant. Eligible service recipients are persons identified by the state through assessment who are eligible for at least 12 hours of personal care assistance each day and are served by workers who have completed designated training approved by the commissioner. The enhanced rate and enhanced budget includes, and is not in addition to, any previously implemented enhanced rates or enhanced budgets for eligible service recipients.

(b) The rate changes described in this section apply to direct support services provided through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision 1.

Sec. 85. **DIRECTION TO COMMISSIONER; INTERAGENCY AGREEMENTS.**

By October 1, 2019, the Department of Commerce, Public Utilities Commission, and Department of Human Services must amend all interagency agreements necessary to implement sections 1 to 10.

Sec. 86. **DISABILITY WAIVER RECONFIGURATION.**

Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance waiver programs for people with disabilities to simplify administration of the programs, incentivize inclusive person-centered supports, enhance each person's personal authority over the person's service choice, align benefits across waivers, encourage equity across programs and populations, and promote long-term sustainability of needed services. To the maximum extent possible, the disability waiver reconfiguration must maintain service

stability and continuity of care, while promoting the most independent and integrated supports of each person's choosing in both short- and long-term planning.

Subd. 2. **Report.** By January 15, 2021, the commissioner of human services shall submit a report to the members of the legislative committees with jurisdiction over human services on any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, any changes to state statute or rule, and any other federal authority necessary to implement this section. The report must include information about the commissioner's work to collect feedback and input from providers, persons accessing home and community-based services waivers and their families, and client advocacy organizations.

Subd. 3. **Proposal.** By January 15, 2021, the commissioner shall develop a proposal to reconfigure the medical assistance waivers provided in sections 256B.092 and 256B.49. The proposal shall include all necessary plans for implementing two home and community-based services waiver programs, as authorized under section 1915(c) of the Social Security Act that serve persons who are determined to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities. Before submitting the final report to the legislature, the commissioner shall publish a draft report with sufficient time for interested persons to offer additional feedback.

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

Sec. 87. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; DIRECT CARE WORKFORCE RATE METHODOLOGY STUDY.**

The commissioner of human services, in consultation with stakeholders, shall evaluate the feasibility of developing a rate methodology for the personal care assistance program under Minnesota Statutes, section 256B.0659, and community first services and supports under Minnesota Statutes, section 256B.85, similar to the disability waiver rate system under Minnesota Statutes, section 256B.4914, including determining the component values and factors to include in such a rate methodology; consider aligning any rate methodology with the collective bargaining agreement and negotiation cycle under Minnesota Statutes, section 179A.54; recommend strategies for ensuring adequate, competitive wages for direct care workers; develop methods and determine the necessary resources for the commissioner to more consistently collect and audit data from the direct care industry; and report recommendations, including proposed draft legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by February 1, 2020.

Sec. 88. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TEFRA OPTION IMPROVEMENT MEASURES.**

(a) The commissioner of human services shall, using existing appropriations, develop content to be included on the MNsure website explaining the TEFRA option under medical assistance for applicants who indicate during the application process that a child in the family has a disability.

(b) The commissioner shall develop a cover letter explaining the TEFRA option under medical assistance, as well as the application and renewal process, to be disseminated with the DHS-6696A form to applicants who may qualify for medical assistance under the TEFRA option. The commissioner shall provide the content and the form to the executive director of MNsure for inclusion on the MNsure website. The commissioner shall also develop and implement education and training for lead agency staff statewide to improve understanding of the medical assistance TEFRA enrollment and renewal processes and procedures.

(c) The commissioner shall convene a stakeholder group that shall consider improvements to the TEFRA option enrollment and renewal processes, including but not limited to revisions to, or the development of, application and renewal paperwork specific to the TEFRA option; possible technology solutions; and county processes.

(d) The stakeholder group must include representatives from the Department of Human Services Health Care Division, MNsure, representatives from at least two counties in the metropolitan area and from at least one county in greater Minnesota, the Arc Minnesota, Gillette Children's Specialty Healthcare, the Autism Society of Minnesota, Proof Alliance, the Minnesota Consortium for Citizens with Disabilities, and other interested stakeholders as identified by the commissioner of human services.

(e) The stakeholder group shall submit a report of the group's recommended improvements and any associated costs to the commissioner by December 31, 2020. The group shall also provide copies of the report to each stakeholder group member. The commissioner shall provide a copy of the report to the legislative committees with jurisdiction over medical assistance.

Sec. 89. **DIRECTION TO COMMISSIONER; RESIDENTIAL SERVICES RATE METHODOLOGY.**

The commissioner of human services shall develop a new rate methodology for residential services, reimbursed under Minnesota Statutes, section 256B.4914, in which the service provider lives in the setting where the service is provided based on levels of support needs.

The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services for the new rate methodology by January 1, 2020.

Sec. 90. **DAY TRAINING AND HABILITATION DISABILITY WAIVER RATE SYSTEM TRANSITION GRANTS.**

(a) The commissioner of human services shall establish annual grants to day training and habilitation providers that are projected to experience a funding gap upon the full implementation of Minnesota Statutes, section 256B.4914.

(b) In order to be eligible for a grant under this section, a day training and habilitation disability waiver provider must:

(1) serve at least 100 waiver service participants;

(2) be projected to receive a reduction in annual revenue from medical assistance for day services during the first year of full implementation of disability waiver rate system framework rates under Minnesota Statutes, section 256B.4914, of at least 15 percent and at least $300,000 compared to the annual medical assistance revenue for day services the provider received during the last full year during which banded rates under Minnesota Statutes, section 256B.4913, subdivision 4a, were effective; and

(3) agree to develop, submit, and implement a sustainability plan as provided in paragraph

(c) A recipient of a grant under this section must develop a sustainability plan in partnership with the commissioner of human services. The sustainability plan must include:

(1) a review of all the provider's costs and an assessment of whether the provider is implementing available cost-control options appropriately;

(2) a review of all the provider's revenue and an assessment of whether the provider is leveraging available resources appropriately; and

(3) a practical strategy for closing the funding gap described in paragraph (b), clause (2).

(d) The commissioner of human services shall provide technical assistance and financial management advice to grant recipients as they develop and implement their sustainability plans.

(e) In order to be eligible for an annual grant renewal, a grant recipient must demonstrate to the commissioner of human services that it made a good faith effort to close the revenue gap described in paragraph (b), clause (2).

Sec. 91. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN COUNTY.**

(a) The commissioner of human services shall allow a housing with services establishment located in Minneapolis that provides customized living and 24-hour customized living services for clients enrolled in the brain injury (BI) or community access for disability inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer service capacity of up to 66 clients to no more than three new housing with services establishments located in Hennepin County.

(b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall determine that the new housing with services establishments described under paragraph (a) meet the BI and CADI waiver customized living and 24-hour customized living size limitation exception for clients receiving those services at the new housing with services establishments described under paragraph (a).

Sec. 92. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; RECOMMENDATIONS TO INCREASE USE OF TECHNOLOGY.**

(a) The commissioner shall appoint under Minnesota Statutes, section 256.01, subdivision 6, a Minnesota Technology First Advisory Task Force to advise the commissioner on strategies to increase the use of supportive technology in services and programs the commissioner administers for persons with disabilities to enable them to live more independently in community settings, work in competitive integrated environments, participate in inclusive community activities, and increase quality of life. The advisory task force must include:

(1) one representative of the Department of Human Services;

(2) two representatives of the counties;

(3) one representative of the Associations of Residential Resources in Minnesota;

(4) one representative from the Minnesota Organization for Habilitation and Rehabilitation;

(5) one representative of the Disability Law Center;

(6) one representative of the Arc Minnesota;

(7) one representative from STAR Services;

(8) one representative from the Traumatic Brain Injury Advisory Committee;

(9) one representative from NAMI Minnesota;

(10) one representative from Advocating Change Together;

(11) two individuals with disabilities accessing supportive technology; and

(12) one parent advocate.

Meetings will be held quarterly and hosted by the department. Subcommittees may be developed as necessary by the commissioner. Advisory task force meetings are subject to the Open Meeting Law under Minnesota Statutes, chapter 13D.

(b) The advisory task force will provide an annual written report with recommendations to the commissioner by June 30 of each year of its existence, beginning June 30, 2020.

(c) Persons with disabilities and family members of persons with disabilities are eligible for compensation for participation in this task force.

(d) The advisory task force expires on June 30, 2021.

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

Sec. 93. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "developmental disability waiver" or similar terms to "developmental disabilities waiver" or similar terms wherever they appear in Minnesota Statutes. The revisor shall also make technical and other necessary changes to sentence structure to preserve the meaning of the text.

(b) The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall prepare legislation for the 2020 legislative session to codify existing session laws governing consumer-directed community supports in Minnesota Statutes, chapter 256B.

(c) The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article 3, section 49, as amended in this act, in Minnesota Statutes, chapter 256B.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2020.

Sec. 94. **REPEALER.**

(a) Minnesota Statutes 2018, section 256B.0705, is repealed.

(b) Minnesota Statutes 2018, sections 252.431; and 252.451, are repealed.

(c) Minnesota Statutes 2018, sections 252.41, subdivision 8; and 256B.4913, subdivisions 4a, 5, 6, and 7, are repealed.

(d) Minnesota Statutes 2018, section 256I.05, subdivision 3, is repealed.

EFFECTIVE DATE. Paragraph (b) is effective September 1, 2019. Paragraphs (a) and (c) are effective January 1, 2020. Paragraph (d) is effective July 1, 2019.

ARTICLE 6
CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2018, section 13.851, is amended by adding a subdivision to read:

Subd. 12. **Mental health screening.** The treatment of data collected by a sheriff or local corrections agency related to individuals who may have a mental illness is governed by section 641.15, subdivision 3a.

Sec. 2. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services~~, including transportation for children receiving school-linked mental health services when school is not in session~~ under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; and

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

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

Sec. 3. **[245.4901] SCHOOL-LINKED MENTAL HEALTH GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a school-linked mental health grant program to provide early identification and intervention

for students with mental health needs and to build the capacity of schools to support students with mental health needs in the classroom.

Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants is an entity that is:

(1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section 245I.16, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions of students;

(2) delivering mental health treatment and services to students and their families, including via telemedicine consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked mental health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked mental health services via telemedicine.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source

excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to the commissioner for the purpose of evaluating the effectiveness of the school-linked mental health grant program.

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

Sec. 4. Minnesota Statutes 2018, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) ~~to be eligible for the prospective payment system in paragraph (f)~~. Entities that choose to be CCBHCs must:

(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to ~~serve~~ meet the needs of the ~~clinic's patient~~ population the clinic serves;

(3) ensure that clinic services are available and accessible to ~~patients~~ individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for ~~nonmedical assistance patients~~ individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to ~~a patient's~~ an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; ~~patient-centered~~ person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services;

and intensive community-based mental health services, including mental health services for members of the armed forces and veterans;

(7) provide coordination of care across settings and providers to ensure seamless transitions for ~~patients~~ individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

~~(9) be certified to provide integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective July 1, 2017;~~

~~(10)~~ (9) comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372, and section 256B.0671;

~~(11)~~ (10) be licensed to provide ~~chemical dependency~~ substance use disorder treatment under chapter 245G;

~~(12)~~ (11) be certified to provide children's therapeutic services and supports under section 256B.0943;

~~(13)~~ (12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

~~(14)~~ (13) be enrolled to provide mental health crisis response services under ~~section~~ sections 256B.0624 and 256B.0944;

~~(15)~~ (14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

~~(16)~~ (15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926; ~~and~~

~~(17)~~ (16) provide services that comply with the evidence-based practices described in paragraph (e)~~.~~; and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under ~~paragraph (f)~~ section 256B.0625, subdivision 5m, for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical

services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

~~(f) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by certified community behavioral health clinics, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for an enhanced federal medical assistance percentage. The commissioner may include quality bonus payment in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.~~

~~(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as CCBHCs during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.~~

~~(h) The commissioner may certify at least one CCBHC located in an urban area and at least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:~~

~~(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and~~

~~(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.~~

~~(i)~~ (f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the

requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2018, section 245F.05, subdivision 2, is amended to read:

Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal management program, the program must make a determination that the program services are appropriate to the needs of the individual. A program may only admit individuals ~~who meet the admission criteria and~~ who, at the time of admission~~:~~, meet the criteria for admission as determined by current American Society of Addiction Medicine standards for appropriate level of withdrawal management.

~~(1) are impaired as the result of intoxication;~~

~~(2) are experiencing physical, mental, or emotional problems due to intoxication or withdrawal from alcohol or other drugs;~~

~~(3) are being held under apprehend and hold orders under section 253B.07, subdivision 2b;~~

~~(4) have been committed under chapter 253B and need temporary placement;~~

~~(5) are held under emergency holds or peace and health officer holds under section 253B.05, subdivision 1 or 2; or~~

~~(6) need to stay temporarily in a protective environment because of a crisis related to substance use disorder. Individuals satisfying this clause may be admitted only at the request of the county of fiscal responsibility, as determined according to section 256G.02, subdivision 4. Individuals admitted according to this clause must not be restricted to the facility.~~

Sec. 6. Minnesota Statutes 2018, section 245G.01, subdivision 8, is amended to read:

Subd. 8. **Client.** "Client" means an individual accepted by a license holder for assessment or treatment of a substance use disorder. An individual remains a client until the license holder no longer provides or intends to provide the individual with treatment service. Client also includes the meaning of patient under section 144.651, subdivision 2.

Sec. 7. Minnesota Statutes 2018, section 245G.01, is amended by adding a subdivision to read:

Subd. 10a. **Day of service initiation.** "Day of service initiation" means the day the license holder begins the provision of a treatment service identified in section 245G.07.

Sec. 8. Minnesota Statutes 2018, section 245G.01, is amended by adding a subdivision to read:

Subd. 13a. **Group counseling.** "Group counseling" means a professionally led psychotherapeutic substance use disorder treatment that is delivered in an interactive group setting.

Sec. 9. Minnesota Statutes 2018, section 245G.01, is amended by adding a subdivision to read:

Subd. 20a. **Person-centered.** "Person-centered" means a client actively participates in the client's treatment planning of services. This includes a client making meaningful and informed choices about the client's own goals, objectives, and the services the client receives in collaboration with the client's identified natural supports.

Sec. 10. Minnesota Statutes 2018, section 245G.01, is amended by adding a subdivision to read:

Subd. 20b. **Staff or staff member.** "Staff" or "staff member" means an individual who works under the direction of the license holder regardless of the individual's employment status including but not limited to an intern, consultant, individual who works part time, or individual who does not provide direct care services.

Sec. 11. Minnesota Statutes 2018, section 245G.01, subdivision 21, is amended to read:

Subd. 21. **Student intern.** "Student intern" means an individual who is enrolled in a program specializing in alcohol and drug counseling or mental health counseling at an accredited educational institution and is authorized by a licensing board to provide services under supervision of a licensed professional.

Sec. 12. Minnesota Statutes 2018, section 245G.01, is amended by adding a subdivision to read:

Subd. 28. **Treatment week.** "Treatment week" means the seven-day period that the program identified in the program's policy and procedure manual as the day of the week

that the treatment program week starts and ends for the purpose of identifying the nature and number of treatment services an individual receives weekly.

Sec. 13. Minnesota Statutes 2018, section 245G.01, is amended by adding a subdivision to read:

Subd. 29. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides services or an activity to a client without compensation.

Sec. 14. Minnesota Statutes 2018, section 245G.04, is amended to read:

245G.04 ~~INITIAL SERVICES PLAN~~ SERVICE INITIATION.

Subdivision 1. **Initial services plan.** ~~(a)~~ The license holder must complete an initial services plan ~~on~~ within 24 hours of the day of service initiation. The plan must be person-centered and client-specific, address the client's immediate health and safety concerns, and identify the treatment needs of the client to be addressed ~~in the first treatment session, and make treatment suggestions for the client~~ during the time between ~~intake~~ the day of service initiation and ~~completion~~ development of the individual treatment plan.

Subd. 2. **Vulnerable adult status.** ~~(b) The initial services plan must include a determination of~~ (a) Within 24 hours of the day of service initiation, a nonresidential program must determine whether a client is a vulnerable adult as defined in section 626.5572, subdivision 21. An adult client of a residential program is a vulnerable adult.

(b) An individual abuse prevention plan, according to sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph (b), is required for a client who meets the definition of vulnerable adult.

Sec. 15. Minnesota Statutes 2018, section 245G.05, is amended to read:

245G.05 COMPREHENSIVE ASSESSMENT AND ASSESSMENT SUMMARY.

Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within three calendar days ~~after~~ from the day of service initiation for a residential program or ~~during the initial session for all other programs~~ within three calendar days on which a treatment session has been provided of the day of service initiation for a client in a nonresidential program. If the comprehensive assessment is not completed ~~during the initial session,~~ within the required time frame, the ~~client-centered~~ person-centered reason for the delay and the planned completion date must be documented in the client's file ~~and~~

~~the planned completion date~~. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review ~~the~~ of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ~~determine~~ ensure compliance with this subdivision~~, including~~ within applicable timelines. ~~If available, the alcohol and drug counselor may use current information provided by a referring agency or other source as a supplement. Information gathered more than 45 days before the date of admission is not considered current.~~ The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:

(1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;

(2) a description of the circumstances on the day of service initiation;

(3) a list of previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;

(4) a list of substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date of the most recent use and address the absence or presence of previous withdrawal symptoms;

(5) specific problem behaviors exhibited by the client when under the influence of substances;

(6) ~~family status~~ the client's desire for family involvement in the treatment program, family history of substance use and misuse, ~~including~~ history or presence of physical or sexual abuse, and level of family support~~, and substance misuse or substance use disorder of a family member or significant other~~;

(7) physical and medical concerns or diagnoses, ~~the severity of the concerns, and~~ current medical treatment needed or being received related to the diagnoses, and whether the concerns ~~are being addressed by a~~ need to be referred to an appropriate health care professional;

(8) mental health history ~~and psychiatric status~~, including symptoms~~, disability,~~ and the effect on the client's ability to function; current mental health treatment ~~supports,~~; and psychotropic medication needed to maintain stability~~;~~. The assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;

(9) arrests and legal interventions related to substance use;

(10) a description of how the client's use affected the client's ability to function appropriately in work and educational settings;

(11) ability to understand written treatment materials, including rules and the client's rights;

(12) a description of any risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;

(13) social network in relation to expected support for recovery ~~and~~;

(14) leisure time activities that are associated with substance use;

~~(14)~~ (15) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;

~~(15)~~ (16) whether the client recognizes ~~problems~~ needs related to substance use and is willing to follow treatment recommendations; and

~~(16) collateral~~ (17) information from a collateral contact may be included, but is not required. ~~If the assessor gathered sufficient information from the referral source or the client to apply the criteria in Minnesota Rules, parts 9530.6620 and 9530.6622, a collateral contact is not required.~~

(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk of and recognizing opioid overdose; and

(4) the use, availability, and administration of naloxone to respond to opioid overdose.

(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.

(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:

(1) the client is in severe withdrawal and likely to be a danger to self or others;

(2) the client has severe medical problems that require immediate attention; or

(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.

If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.

Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an assessment summary within three calendar days ~~after~~ from the day of service initiation for a residential program and within three ~~sessions for all other programs~~ calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. The comprehensive assessment summary is complete upon a qualified staff member's dated signature. If the comprehensive assessment is used to authorize the treatment service, the alcohol and drug counselor must prepare an assessment summary on the same date the comprehensive assessment is completed. If the comprehensive assessment and assessment summary are to authorize treatment services, the assessor must determine appropriate services for the client using the dimensions in Minnesota Rules, part 9530.6622, and document the recommendations.

(b) An assessment summary must include:

(1) a risk description according to section 245G.05 for each dimension listed in paragraph (c);

(2) a narrative summary supporting the risk descriptions; and

(3) a determination of whether the client has a substance use disorder.

(c) An assessment summary must contain information relevant to treatment service planning and recorded in the dimensions in clauses (1) to (6). The license holder must consider:

(1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with withdrawal symptoms and current state of intoxication;

(2) Dimension 2, biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued ~~chemical~~ substance use on the unborn child, if the client is pregnant;

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas and the likelihood of harm to self or others;

(4) Dimension 4, readiness for change; the support necessary to keep the client involved in treatment service;

(5) Dimension 5, relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems; and

(6) Dimension 6, recovery environment; whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

Sec. 16. Minnesota Statutes 2018, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have ~~an~~ a person-centered individual treatment plan developed by an alcohol and drug counselor within ~~seven~~ ten days from the day of service initiation for a residential program and within ~~three sessions for all other programs~~ five calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. ~~The client must have active, direct involvement in selecting the anticipated outcomes of the treatment process and developing the treatment plan.~~ The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. ~~The plan may be a continuation of the initial services plan required in section 245G.04.~~ The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. ~~The plan must provide for the involvement of the client's family and people selected by the client as important to the success of treatment at the earliest opportunity, consistent with the client's treatment needs and written consent.~~

If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment.

Sec. 17. Minnesota Statutes 2018, section 245G.06, subdivision 2, is amended to read:

Subd. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), must address each issue identified in the assessment summary, prioritized according to the client's needs and focus, and must include:

(1) specific goals and methods to address each identified need in the comprehensive assessment summary, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

(2) resources to refer the client to when the client's needs are to be addressed concurrently by another provider; and

(3) goals the client must reach to complete treatment and terminate services.

Sec. 18. Minnesota Statutes 2018, section 245G.06, subdivision 4, is amended to read:

Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a service discharge summary for each client. The service discharge summary must be completed within five days of the client's service termination ~~or within five days from the client's or program's decision to terminate services, whichever is earlier~~. A copy of the client's service discharge summary must be provided to the client upon the client's request.

(b) The service discharge summary must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), and include the following information:

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk description according to section 245G.05; ~~and~~

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the ~~program's policies on staff-initiated~~

~~client discharge. If a client is discharged at staff request, the program must give the client crisis and other referrals appropriate for the client's needs and offer assistance to the client to access the services.~~ requirements in section 245G.14, subdivision 3, clause (3);

~~(c) For a client who successfully completes treatment, the summary must also include:~~

~~(1)~~ (5) the client's living arrangements at service termination;

~~(2)~~ (6) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and

~~(3)~~ (7) service termination diagnosis~~; and~~.

~~(4) the client's prognosis.~~

Sec. 19. Minnesota Statutes 2018, section 245G.07, is amended to read:

245G.07 TREATMENT SERVICE.

Subdivision 1. **Treatment service.** (a) A ~~license holder~~ licensed residential treatment program must offer the ~~following~~ treatment services in clauses (1) to (5) to each client, unless clinically inappropriate and the justifying clinical rationale is documented~~:~~. A nonresidential treatment program must offer all treatment services in clauses (1) to (5) and document in the individual treatment plan the specific services for which a client has an assessed need and the plan to provide the services:

(1) individual and group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder;

(2) client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis~~. A licensed alcohol and drug counselor must be present during an educational group~~;

(3) a service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support;

(4) a service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued

medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan; and

~~(5) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided one-to-one by an individual in recovery. Peer support services include education, advocacy, mentoring through self-disclosure of personal recovery experiences, attending recovery and other support groups with a client, accompanying the client to appointments that support recovery, assistance accessing resources to obtain housing, employment, education, and advocacy services, and nonclinical recovery support to assist the transition from treatment into the recovery community; and~~

~~(6) on July 1, 2018, or upon federal approval, whichever is later, care~~ (5) treatment coordination provided one-to-one by an individual who meets the staff qualifications in section 245G.11, subdivision 7. ~~Care~~ Treatment coordination services include:

(i) assistance in coordination with significant others to help in the treatment planning process whenever possible;

(ii) assistance in coordination with and follow up for medical services as identified in the treatment plan;

(iii) facilitation of referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan;

(iv) facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan;

(v) assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;

(vi) life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and

(vii) documentation of the provision of ~~care~~ treatment coordination services in the client's file.

(b) A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client.

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner; ~~and~~

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills; and

(8) peer recovery support services provided one-to-one by an individual in recovery qualified according to section 245G.11, subdivision 8. Peer support services include education; advocacy; mentoring through self-disclosure of personal recovery experiences; attending recovery and other support groups with a client; accompanying the client to appointments that support recovery; assistance accessing resources to obtain housing, employment, education, and advocacy services; and nonclinical recovery support to assist the transition from treatment into the recovery community.

Subd. 3. **Counselors.** ~~A~~ All treatment ~~service~~ services, ~~including therapeutic recreation~~ except peer recovery support services and treatment coordination, must be provided by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5, unless the individual providing the service is specifically qualified according to the accepted credential required to provide the service. ~~Therapeutic recreation does not include planned leisure activities.~~ The commissioner shall maintain a current list of professionals qualified to provide treatment services.

Subd. 4. **Location of service provision.** The license holder may provide services at any of the license holder's licensed locations or at another suitable location including a school, government building, medical or behavioral health facility, or social service organization,

upon notification and approval of the commissioner. If services are provided off site from the licensed site, the reason for the provision of services remotely must be documented. The license holder may provide additional services under subdivision 2, clauses (2) to (5), off-site if the license holder includes a policy and procedure detailing the off-site location as a part of the treatment service description and the program abuse prevention plan.

Sec. 20. Minnesota Statutes 2018, section 245G.08, subdivision 3, is amended to read:

Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone available for emergency treatment of opioid overdose must have a written standing order protocol by a physician who is licensed under chapter 147, that permits the license holder to maintain a supply of naloxone on site~~, and~~. A license holder must require staff to undergo ~~specific~~ training in ~~administration of naloxone~~ the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both.

Sec. 21. Minnesota Statutes 2018, section 245G.10, subdivision 4, is amended to read:

Subd. 4. **Staff requirement.** It is the responsibility of the license holder to determine an acceptable group size based on each client's needs ~~except that treatment services provided in a~~. Group counseling shall not exceed 16 clients. ~~A counselor in an opioid treatment program must not supervise more than 50 clients.~~ The license holder must maintain a record that documents compliance with this subdivision.

Sec. 22. Minnesota Statutes 2018, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **~~Care~~ Treatment coordination provider qualifications.** (a) ~~Care~~ Treatment coordination must be provided by qualified staff. An individual is qualified to provide ~~care~~ treatment coordination if the individual~~:~~ meets the qualifications of an alcohol and drug counselor under subdivision 5 or if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed 30 hours of classroom instruction on ~~care~~ treatment coordination for an individual with substance use disorder;

(4) has either:

(i) a bachelor's degree in one of the behavioral sciences or related fields; or

(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and

(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.

(b) A ~~care~~ treatment coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor ~~weekly~~ monthly.

Sec. 23. Minnesota Statutes 2018, section 245G.11, subdivision 8, is amended to read:

Subd. 8. **Recovery peer qualifications.** A recovery peer must:

(1) have a high school diploma or its equivalent;

(2) have a minimum of one year in recovery from substance use disorder;

(3) hold a current credential from ~~a certification body approved by the commissioner that demonstrates~~ the Minnesota Certification Board, the Upper Midwest Indian Council on Addictive Disorders, or the National Association for Alcoholism and Drug Abuse Counselors. An individual may also receive a credential from a tribal nation when providing peer recovery support services in a tribally licensed program. The credential must demonstrate skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and

(4) receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor ~~or an individual with a certification approved by the commissioner~~.

Sec. 24. Minnesota Statutes 2018, section 245G.12, is amended to read:

245G.12 PROVIDER POLICIES AND PROCEDURES.

A license holder must develop a written policies and procedures manual, indexed according to section 245A.04, subdivision 14, paragraph (c), that provides staff members immediate access to all policies and procedures and provides a client and other authorized parties access to all policies and procedures. The manual must contain the following materials:

(1) assessment and treatment planning policies, including screening for mental health concerns and treatment objectives related to the client's identified mental health concerns in the client's treatment plan;

(2) policies and procedures regarding HIV according to section 245A.19;

(3) the license holder's methods and resources to provide information on tuberculosis and tuberculosis screening to each client and to report a known tuberculosis infection according to section 144.4804;

(4) personnel policies according to section 245G.13;

(5) policies and procedures that protect a client's rights according to section 245G.15;

(6) a medical services plan according to section 245G.08;

(7) emergency procedures according to section 245G.16;

(8) policies and procedures for maintaining client records according to section 245G.09;

(9) procedures for reporting the maltreatment of minors according to section 626.556, and vulnerable adults according to sections 245A.65, 626.557, and 626.5572;

(10) a description of treatment services~~, including the amount and type of services provided~~ that: (i) includes the amount and type of services provided; (ii) identifies which services meet the definition of group counseling under section 245G.01, subdivision 13a; and (iii) defines the program's treatment week;

(11) the methods used to achieve desired client outcomes;

(12) the hours of operation; and

(13) the target population served.

Sec. 25. Minnesota Statutes 2018, section 245G.13, subdivision 1, is amended to read:

Subdivision 1. **Personnel policy requirements.** A license holder must have written personnel policies that are available to each staff member. The personnel policies must:

(1) ensure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the department, the Department of Health, the ombudsman for mental health and developmental disabilities, law enforcement, or a local agency for the investigation of a complaint regarding a client's rights, health, or safety;

(2) contain a job description for each staff member position specifying responsibilities, degree of authority to execute job responsibilities, and qualification requirements;

(3) provide for a job performance evaluation based on standards of job performance conducted on a regular and continuing basis, including a written annual review;

(4) describe behavior that constitutes grounds for disciplinary action, suspension, or dismissal, including policies that address staff member problematic substance use and the requirements of section 245G.11, subdivision 1, policies prohibiting personal involvement with a client in violation of chapter 604, and policies prohibiting client abuse described in sections 245A.65, 626.556, 626.557, and 626.5572;

(5) identify how the program will identify whether behaviors or incidents are problematic substance use, including a description of how the facility must address:

(i) receiving treatment for substance use within the period specified for the position in the staff qualification requirements, including medication-assisted treatment;

(ii) substance use that negatively impacts the staff member's job performance;

(iii) ~~chemical~~ substance use that affects the credibility of treatment services with a client, referral source, or other member of the community;

(iv) symptoms of intoxication or withdrawal on the job; and

(v) the circumstances under which an individual who participates in monitoring by the health professional services program for a substance use or mental health disorder is able to provide services to the program's clients;

(6) include a chart or description of the organizational structure indicating lines of authority and responsibilities;

(7) include orientation within 24 working hours of starting for each new staff member based on a written plan that, at a minimum, must provide training related to the staff member's specific job responsibilities, policies and procedures, client confidentiality, HIV minimum standards, and client needs; and

(8) include policies outlining the license holder's response to a staff member with a behavior problem that interferes with the provision of treatment service.

Sec. 26. Minnesota Statutes 2018, section 245G.15, subdivision 1, is amended to read:

Subdivision 1. **Explanation.** A client has the rights identified in sections 144.651, 148F.165, and 253B.03, as applicable. The license holder must give each client ~~at~~ on the day of service initiation a written statement of the client's rights and responsibilities. A staff member must review the statement with a client at that time.

Sec. 27. Minnesota Statutes 2018, section 245G.15, subdivision 2, is amended to read:

Subd. 2. **Grievance procedure.** ~~At~~ On the day of service initiation, the license holder must explain the grievance procedure to the client or the client's representative. The grievance procedure must be posted in a place visible to clients, and made available upon a client's or former client's request. The grievance procedure must require that:

(1) a staff member helps the client develop and process a grievance;

(2) current telephone numbers and addresses of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health Office of Health Facilities Complaints; and the Board of Behavioral Health and Therapy, when applicable, be made available to a client; and

(3) a license holder responds to the client's grievance within three days of a staff member's receipt of the grievance, and the client may bring the grievance to the highest level of authority in the program if not resolved by another staff member.

Sec. 28. Minnesota Statutes 2018, section 245G.18, subdivision 3, is amended to read:

Subd. 3. **Staff ratios.** ~~At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties.~~ A counseling group consisting entirely of adolescents must not exceed 16 adolescents. It is the responsibility of the license holder to determine an acceptable group size based on the needs of the clients.

Sec. 29. Minnesota Statutes 2018, section 245G.18, subdivision 5, is amended to read:

Subd. 5. **Program requirements.** In addition to the requirements specified in the client's treatment plan under section 245G.06, programs serving an adolescent must include:

(1) coordination with the school system to address the client's academic needs;

(2) when appropriate, a plan that addresses the client's leisure activities without ~~chemical~~ substance use; and

(3) a plan that addresses family involvement in the adolescent's treatment.

Sec. 30. Minnesota Statutes 2018, section 245G.22, subdivision 1, is amended to read:

Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed under this chapter must also: (1) comply with the requirements of this section and Code of Federal Regulations, title 42, part 8~~. When federal guidance or interpretations are issued on~~

~~federal standards or requirements also required under this section, the federal guidance or interpretations shall apply.~~; (2) be registered as a narcotic treatment program with the Drug Enforcement Administration; (3) be accredited through an accreditation body approved by the Division of Pharmacologic Therapy of the Center for Substance Abuse Treatment; (4) be certified through the Division of Pharmacologic Therapy of the Center for Substance Abuse Treatment; and (5) hold a license from the Minnesota Board of Pharmacy or equivalent agency.

(b) Where a standard in this section differs from a standard in an otherwise applicable administrative rule or statute, the standard of this section applies.

Sec. 31. Minnesota Statutes 2018, section 245G.22, subdivision 2, is amended to read:

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

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from intended use of the medication.

(c) "Guest dose" means administration of a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a ~~physician~~ practitioner licensed to practice medicine in the jurisdiction that the opioid treatment program is located who assumes responsibility for administering all medical services performed by the program, either by performing the services directly or by delegating specific responsibility to ~~(1) authorized program physicians; (2) advanced practice registered nurses, when approved by variance by the State Opioid Treatment Authority under section 254A.03 and the federal Substance Abuse and Mental Health Services Administration; or (3) health care professionals functioning under the medical director's direct supervision~~ a practitioner of the opioid treatment program.

(e) "Medication used for the treatment of opioid use disorder" means a medication approved by the Food and Drug Administration for the treatment of opioid use disorder.

(f) "Minnesota health care programs" has the meaning given in section 256B.0636.

(g) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under this chapter.

(h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(i) "Practitioner" means a staff member holding a current, unrestricted license to practice medicine issued by the Board of Medical Practice or nursing issued by the Board of Nursing and is currently registered with the Drug Enforcement Administration to order or dispense controlled substances in Schedules II to V under the Controlled Substances Act, United States Code, title 21, part B, section 821. Practitioner includes an advanced practice registered nurse and physician assistant if the staff member receives a variance by the state opioid treatment authority under section 254A.03 and the federal Substance Abuse and Mental Health Services Administration.

~~(i)~~ (j) "Unsupervised use" means the use of a medication for the treatment of opioid use disorder dispensed for use by a client outside of the program setting.

Sec. 32. Minnesota Statutes 2018, section 245G.22, subdivision 3, is amended to read:

Subd. 3. **Medication orders.** Before the program may administer or dispense a medication used for the treatment of opioid use disorder:

(1) a client-specific order must be received from an appropriately credentialed ~~physician~~ practitioner who is enrolled as a Minnesota health care programs provider and meets all applicable provider standards;

(2) the signed order must be documented in the client's record; and

(3) if the ~~physician~~ practitioner that issued the order is not able to sign the order when issued, the unsigned order must be entered in the client record at the time it was received, and the ~~physician~~ practitioner must review the documentation and sign the order in the client's record within 72 hours of the medication being ordered. The license holder must report to the commissioner any medication error that endangers a client's health, as determined by the medical director.

Sec. 33. Minnesota Statutes 2018, section 245G.22, subdivision 4, is amended to read:

Subd. 4. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 6, paragraph (a), ~~clause (1),~~ that exceeds 150 milligrams of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing ~~physician~~ practitioner. The meeting must occur before the administration or dispensing of the increased medication dose.

Sec. 34. Minnesota Statutes 2018, section 245G.22, subdivision 6, is amended to read:

Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid use disorder to the illicit market, medication dispensed to a client for unsupervised use shall be subject to the ~~following~~ requirements~~:~~ of this subdivision.

~~(1)~~ Any client in an opioid treatment program may receive a single unsupervised use dose for a day that the clinic is closed for business, including Sundays and state and federal holidays~~; and~~.

~~(2) other treatment program decisions on dispensing medications used for the treatment of opioid use disorder to a client for unsupervised use shall be determined by the medical director.~~

(b) ~~In determining whether a client may be permitted unsupervised use of medications,~~ ~~a physician~~ A practitioner with authority to prescribe must ~~consider~~ review and document the criteria in this paragraph~~. The criteria in this paragraph must also be considered~~ and paragraph (c) when determining whether dispensing medication for a client's unsupervised use is appropriate to implement, increase, or ~~to~~ extend the amount of time between visits to the program. The criteria are:

(1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics, and alcohol;

(2) regularity of program attendance;

(3) absence of serious behavioral problems at the program;

(4) absence of known recent criminal activity such as drug dealing;

(5) stability of the client's home environment and social relationships;

(6) length of time in comprehensive maintenance treatment;

(7) reasonable assurance that unsupervised use medication will be safely stored within the client's home; and

(8) whether the rehabilitative benefit the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion or unsupervised use.

(c) The determination, including the basis of the determination must be documented in the client's medical record.

Sec. 35. Minnesota Statutes 2018, section 245G.22, subdivision 7, is amended to read:

Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a ~~physician with authority to prescribe~~ medical director or prescribing practitioner assesses and determines that a client meets the criteria in subdivision 6 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in this subdivision must be followed when the medication to be dispensed is methadone hydrochloride. The results of the assessment must be contained in the client file.

(b) During the first 90 days of treatment, the unsupervised use medication supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the unsupervised use medication supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the unsupervised use medication supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day unsupervised use medication supply.

(f) After one year of continuous treatment, a client may be given a maximum two-week unsupervised use medication supply.

(g) After two years of continuous treatment, a client may be given a maximum one-month unsupervised use medication supply, but must make monthly visits to the program.

Sec. 36. Minnesota Statutes 2018, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following ~~admission~~ the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:

(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated; and

(3) for the ~~initial~~ ten weeks ~~after admission~~ following the day of service initiation for all new admissions, readmissions, and transfers, ~~progress notes~~ a weekly treatment plan review must be ~~entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of~~ documented once the treatment plan ~~and thereafter~~ is completed. Subsequently, the counselor must document ~~progress~~ treatment plan reviews in the six dimensions at least once monthly or, when clinical need warrants, more frequently~~; and~~.

~~(4) upon the development of the treatment plan and thereafter, treatment plan reviews must occur weekly, or after each treatment service, whichever is less frequent, for the first ten weeks after the treatment plan is developed. Following the first ten weeks of treatment plan reviews, reviews may occur monthly, unless the client's needs warrant more frequent revisions or documentation.~~

Sec. 37. Minnesota Statutes 2018, section 245G.22, subdivision 16, is amended to read:

Subd. 16. **Prescription monitoring program.** (a) The program must develop and maintain a policy and procedure that requires the ongoing monitoring of the data from the prescription monitoring program (PMP) for each client. The policy and procedure must include how the program meets the requirements in paragraph (b).

(b) ~~If~~ When a medication used for the treatment of substance use disorder is administered or dispensed to a client, the license holder ~~shall be~~ is subject to the following requirements:

(1) upon admission to ~~a methadone clinic outpatient~~ an opioid treatment program, a client must be notified in writing that the commissioner of human services and the medical director must monitor the PMP to review the prescribed controlled drugs a client received;

(2) the medical director or the medical director's delegate must review the data from the PMP described in section 152.126 before the client is ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and the medical director's or the medical director's delegate's subsequent reviews of the PMP data must occur at least every 90 days;

(3) a copy of the PMP data reviewed must be maintained in the client's file along with the licensed practitioner's decision for frequency of ongoing PMP checks;

(4) when the PMP data contains a recent history of multiple prescribers or multiple prescriptions for controlled substances, the physician's review of the data and subsequent actions must be documented in the client's file within 72 hours and must contain the ~~medical director's~~ licensed practitioner's determination of whether or not the prescriptions place the client at risk of harm and the actions to be taken in response to the PMP findings. The provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the ~~medical director~~ licensed practitioner believes the use of the controlled substances places the client at risk of harm, the program must seek the client's consent to discuss the client's opioid treatment with other prescribers and must seek the client's consent for the other prescriber to disclose to the opioid treatment program's ~~medical director~~ licensed practitioner the client's condition that formed the basis of the other prescriptions. If the information is not obtained within seven days, the medical director must document whether or not changes to the client's medication dose or number of unsupervised use doses are necessary until the information is obtained.

(c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and implement an electronic system for the commissioner to routinely access the PMP data to determine whether any client enrolled in an opioid addiction treatment program licensed according to this section was prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid addiction treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances for a client, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

(d) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34 (c), before implementing this subdivision.

Sec. 38. Minnesota Statutes 2018, section 245G.22, subdivision 17, is amended to read:

Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the policies and procedures required in this subdivision.

(b) For a program that is not open every day of the year, the license holder must maintain a policy and procedure that ~~permits a client to receive a single~~ covers requirements under section 245G.22, subdivisions 6 and 7. Unsupervised use of medication used for the treatment of opioid use disorder for days that the program is closed for business, including~~,~~ but not limited to~~,~~ Sundays and state and federal holidays ~~as required under subdivision 6, paragraph (a), clause (1)~~, must meet the requirements under section 245G.22, subdivisions 6 and 7.

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of diversion. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for performing diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication, excluding clients approved solely under subdivision 6, paragraph (a), ~~clause (1),~~ to require clients to physically return to the program each month. The system must require clients to return to the program within a stipulated time frame and turn in all unused medication containers related to opioid use disorder treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the client's record. The medical director must be informed of each outcome that results in a situation in which a possible diversion issue was identified.

(d) Medication used for the treatment of opioid use disorder must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. If a medication order requires assessment by the person administering or dispensing the medication to determine the amount to be administered or dispensed, the assessment must be completed by an individual whose professional scope of practice permits an assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor the person administering or dispensing the medication for compliance with state and federal regulations and the relevant standards of the license holder's accreditation agency and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's determination of noncompliance.

(e) A counselor in an opioid treatment program must not supervise more than 50 clients.

Sec. 39. Minnesota Statutes 2018, section 245G.22, subdivision 19, is amended to read:

Subd. 19. **Placing authorities.** A program must provide certain notification and client-specific updates to placing authorities for a client who is enrolled in Minnesota health care programs. At the request of the placing authority, the program must provide client-specific updates, including but not limited to informing the placing authority of positive drug ~~screenings~~ testings and changes in medications used for the treatment of opioid use disorder ordered for the client.

Sec. 40. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include any combination of up to four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 41. Minnesota Statutes 2018, section 254A.19, is amended by adding a subdivision to read:

Subd. 5. **Assessment via telemedicine.** Notwithstanding Minnesota Rules, part 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via telemedicine.

Sec. 42. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder of the~~ money in the special revenue account must be used according to the requirements in this chapter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 43. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but

is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors ~~certified according to~~ meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 44. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services,

~~including~~ except for those services provided to persons ~~eligible for~~ enrolled in medical assistance under chapter 256B and room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12). Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

~~(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are equal to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 45. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or~~ who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

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

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12).

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 46. Minnesota Statutes 2018, section 254B.04, is amended by adding a subdivision to read:

Subd. 2c. **Eligibility to receive peer recovery support and treatment service coordination.** Notwithstanding Minnesota Rules, part 9530.6620, subpart 6, a placing

authority may authorize peer recovery support and treatment service coordination for a person who scores a severity of one or more in dimension 4, 5, or 6, under Minnesota Rules, part 9530.6622. Authorization for peer recovery support and treatment service coordination under this subdivision does not need to be provided in conjunction with treatment services under Minnesota Rules, part 9530.6622, subpart 4, 5, or 6.

Sec. 47. Minnesota Statutes 2018, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) ~~On July 1, 2018, or upon federal approval, whichever is later,~~ A licensed professional in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to ~~(5)~~ (4), and (b); and subdivision 2.

(c) ~~On July 1, 2018, or upon federal approval, whichever is later,~~ A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and ~~4~~ 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause ~~(7)~~ (5).

(d) ~~On July 1, 2018, or upon federal approval, whichever is later,~~ A recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

(e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

Sec. 48. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 49. Minnesota Statutes 2018, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) ~~on July 1, 2018, or upon federal approval, whichever is later,~~ comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05~~, and Minnesota Rules, part 9530.6422~~;

(3) ~~on July 1, 2018, or upon federal approval, whichever is later,~~ care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause ~~(6)~~ (5);

(4) ~~on July 1, 2018, or upon federal approval, whichever is later,~~ peer recovery support services provided according to section 245G.07, subdivision ~~1, paragraph (a)~~ 2, clause ~~(5)~~ (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs

treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

Sec. 50. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for chemical dependency services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit in a dedicated account a percentage of collections to pay for the cost of operating the chemical dependency consolidated treatment fund invoice processing and vendor payment system, billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency fund.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 51. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal financial participation collections to a special revenue account.~~ The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility shall be reduced from 22.95 percent to 20.2 percent.~~

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2020, and paragraph (b) is effective July 1, 2019.

Sec. 52. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. The commissioner shall include a quality bonus payment in the prospective payment system based on federal criteria.

(c) To the extent allowed by federal law, the commissioner may limit the number of CCBHCs for the prospective payment system in paragraph (b) to ensure that the projected claims do not exceed the money appropriated for this purpose. The commissioner shall apply the following priorities, in the order listed, to give preference to clinics that:

(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated;

(2) are certified as CCBHCs during the federal section 223 CCBHC demonstration period;

(3) receive CCBHC grants from the United States Department of Health and Human Services; or

(4) focus on serving individuals in tribal areas and other underserved communities.

(d) Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal section 223 CCBHC demonstration, except:

(1) the commissioner shall rebase CCBHC rates at least every three years;

(2) the commissioner shall provide for a 60-day appeals process of the rebasing;

(3) the prohibition against inclusion of new facilities in the demonstration does not apply after the demonstration ends;

(4) the prospective payment rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(5) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments;

(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services; and

(7) the prospective payment rate for each CCBHC shall be adjusted annually by the Medicare Economic Index as defined for the federal section 223 CCBHC demonstration.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 53. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law~~, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B~~. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 54. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use disorder treatment services according to section 254B.05, subdivision 5, except for room and board.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 55. Minnesota Statutes 2018, section 256B.0625, subdivision 43, is amended to read:

Subd. 43. **Mental health provider travel time.** (a) Medical assistance covers provider travel time if a ~~recipient's individual treatment plan~~ recipient requires the provision of mental health services outside of the provider's ~~normal~~ usual place of business. ~~This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.~~

(b) Medical assistance covers under this subdivision the time a provider is in transit to provide a covered mental health service to a recipient at a location that is not the provider's usual place of business. A provider must travel the most direct route available. Mental health provider travel time does not include time for scheduled or unscheduled stops, meal breaks, or vehicle maintenance or repair, including refueling or vehicle emergencies. Recipient transportation is not covered under this subdivision.

(c) Mental health provider travel time under this subdivision is only covered when the mental health service being provided is covered under medical assistance and only when the covered mental health service is delivered and billed. Mental health provider travel time is not covered when the mental health service being provided otherwise includes provider travel time or when the service is site based.

(d) A provider must document each trip for which the provider seeks reimbursement under this subdivision in a compiled travel record. Required documentation may be collected and maintained electronically or in paper form but must be made available and produced upon request by the commissioner. The travel record must be written in English and must be legible according to the standard of a reasonable person. The recipient's individual identification number must be on each page of the record. The reason the provider must travel to provide services must be included in the record, if not otherwise documented in the recipient's individual treatment plan. Each entry in the record must document:

(1) start and stop time (with a.m. and p.m. notations);

(2) printed name of the recipient;

(3) date the entry is made;

(4) date the service is provided;

(5) origination site and destination site;

(6) who provided the service;

(7) the electronic source used to calculate driving directions and distance between locations; and

(8) the medically necessary mental health service delivered.

(e) Mental health providers identified by the commissioner to have submitted a fraudulent report may be excluded from participation in Minnesota health care programs.

Sec. 56. Minnesota Statutes 2018, section 256B.0625, subdivision 45a, is amended to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons younger than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons younger than 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds ~~at up to six sites~~. The commissioner may enroll an additional 80 certified psychiatric residential treatment facility services beds beginning July 1, 2020, and an additional 70 certified psychiatric residential treatment facility services beds beginning July 1, 2023. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals. The commissioner shall prioritize programs that demonstrate the capacity to serve children and youth with aggressive and risky behaviors toward themselves or others, multiple diagnoses, neurodevelopmental disorders, or complex trauma related issues.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 57. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers ~~and~~, rural health clinics, and CCBHCs subject to the prospective payment system under subdivision 5m.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 58. Minnesota Statutes 2018, section 256B.0757, subdivision 1, is amended to read:

Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical assistance coverage of health home services for eligible individuals with chronic conditions who select a designated provider as the individual's health home.

(b) The commissioner shall implement this section in compliance with the requirements of the state option to provide health homes for enrollees with chronic conditions, as provided under the Patient Protection and Affordable Care Act, Public Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning provided in that act.

(c) The commissioner shall establish health homes to serve populations with serious mental illness who meet the eligibility requirements described under subdivision 2~~, clause (4)~~. The health home services provided by health homes shall focus on both the behavioral and the physical health of these populations.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 59. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home models in accordance with United States Code, title 42, section 1396w-4.

(b) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has ~~at least:~~

~~(1) two chronic conditions;~~

~~(2) one chronic condition and is at risk of having a second chronic condition;~~

~~(3) one serious and persistent mental health condition; or~~

~~(4)~~ a condition that meets the definition of mental illness as described in section 245.462, subdivision 20, paragraph (a), or emotional disturbance as defined in section 245.4871, subdivision 15, clause (2)~~; and has a current diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C, as performed or reviewed by a mental health professional employed by or under contract with the behavioral health home~~. The commissioner shall establish criteria for determining continued eligibility.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 60. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 2a. **Discharge criteria.** (a) An individual may be discharged from behavioral health home services if:

(1) the behavioral health home services provider is unable to locate, contact, and engage the individual for a period of greater than three months after persistent efforts by the behavioral health home services provider; or

(2) the individual is unwilling to participate in behavioral health home services as demonstrated by the individual's refusal to meet with the behavioral health home services provider, or refusal to identify the individual's health and wellness goals or the activities or support necessary to achieve these goals.

(b) Before discharge from behavioral health home services, the behavioral health home services provider must offer a face-to-face meeting with the individual, the individual's identified supports, and the behavioral health home services provider to discuss options available to the individual, including maintaining behavioral health home services.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 61. Minnesota Statutes 2018, section 256B.0757, subdivision 4, is amended to read:

Subd. 4. **Designated provider.** ~~(a)~~ Health home services are voluntary and an eligible individual may choose any designated provider. The commissioner shall establish designated providers to serve as health homes and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health homes and provide capitated payments to designated providers. For purposes of this section, "designated provider" means a provider, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or any other entity that is determined by the commissioner to be qualified to be a health home for eligible individuals. This determination must be based on documentation evidencing that the designated provider has the systems and infrastructure in place to provide health home services and satisfies the qualification standards established by the commissioner in consultation with stakeholders and approved by the Centers for Medicare and Medicaid Services.

~~(b) The commissioner shall develop and implement certification standards for designated providers under this subdivision.~~

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 62. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4a. **Behavioral health home services provider requirements.** A behavioral health home services provider must:

(1) be an enrolled Minnesota Health Care Programs provider;

(2) provide a medical assistance covered primary care or behavioral health service;

(3) utilize an electronic health record;

(4) utilize an electronic patient registry that contains data elements required by the commissioner;

(5) demonstrate the organization's capacity to administer screenings approved by the commissioner for substance use disorder or alcohol and tobacco use;

(6) demonstrate the organization's capacity to refer an individual to resources appropriate to the individual's screening results;

(7) have policies and procedures to track referrals to ensure that the referral met the individual's needs;

(8) conduct a brief needs assessment when an individual begins receiving behavioral health home services. The brief needs assessment must be completed with input from the individual and the individual's identified supports. The brief needs assessment must address the individual's immediate safety and transportation needs and potential barriers to participating in behavioral health home services;

(9) conduct a health wellness assessment within 60 days after intake that contains all required elements identified by the commissioner;

(10) conduct a health action plan that contains all required elements identified by the commissioner. The plan must be completed within 90 days after intake and must be updated at least once every six months, or more frequently if significant changes to an individual's needs or goals occur;

(11) agree to cooperate with and participate in the state's monitoring and evaluation of behavioral health home services; and

(12) obtain the individual's written consent to begin receiving behavioral health home services using a form approved by the commissioner.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 63. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4b. **Behavioral health home provider training and practice transformation requirements.** (a) The behavioral health home services provider must ensure that all staff delivering behavioral health home services receive adequate preservice and ongoing training, including:

(1) training approved by the commissioner that describes the goals and principles of behavioral health home services; and

(2) training on evidence-based practices to promote an individual's ability to successfully engage with medical, behavioral health, and social services to achieve the individual's health and wellness goals.

(b) The behavioral health home services provider must ensure that staff are capable of implementing culturally responsive services, as determined by the individual's culture, beliefs, values, and language as identified in the individual's health wellness assessment.

(c) The behavioral health home services provider must participate in the department's practice transformation activities to support continued skill and competency development in the provision of integrated medical, behavioral health, and social services.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 64. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4c. **Behavioral health home staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner as defined in section 245.462, subdivision 17, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a peer support specialist as defined in section 256B.0615;

(2) a family peer support specialist as defined in section 256B.0616;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker as defined in section 256B.0623, subdivision 5, clause (4);

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5); or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 65. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4d. **Behavioral health home service delivery standards.** (a) A behavioral health home services provider must meet the following service delivery standards:

(1) establish and maintain processes to support the coordination of an individual's primary care, behavioral health, and dental care;

(2) maintain a team-based model of care, including regular coordination and communication between behavioral health home services team members;

(3) use evidence-based practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting the individual's health and health care choices;

(4) use person-centered planning practices to ensure the individual's health action plan accurately reflects the individual's preferences, goals, resources, and optimal outcomes for the individual and the individual's identified supports;

(5) use the patient registry to identify individuals and population subgroups requiring specific levels or types of care and provide or refer the individual to needed treatment, intervention, or services;

(6) utilize the Department of Human Services Partner Portal to identify past and current treatment or services and identify potential gaps in care;

(7) deliver services consistent with the standards for frequency and face-to-face contact required by the commissioner;

(8) ensure that a diagnostic assessment is completed for each individual receiving behavioral health home services within six months of the start of behavioral health home services;

(9) deliver services in locations and settings that meet the needs of the individual;

(10) provide a central point of contact to ensure that individuals and the individual's identified supports can successfully navigate the array of services that impact the individual's health and well-being;

(11) have capacity to assess an individual's readiness for change and the individual's capacity to integrate new health care or community supports into the individual's life;

(12) offer or facilitate the provision of wellness and prevention education on evidenced-based curriculums specific to the prevention and management of common chronic conditions;

(13) help an individual set up and prepare for medical, behavioral health, social service, or community support appointments, including accompanying the individual to appointments as appropriate, and providing follow-up with the individual after these appointments;

(14) offer or facilitate the provision of health coaching related to chronic disease management and how to navigate complex systems of care to the individual, the individual's family, and identified supports;

(15) connect an individual, the individual's family, and identified supports to appropriate support services that help the individual overcome access or service barriers, increase self-sufficiency skills, and improve overall health;

(16) provide effective referrals and timely access to services; and

(17) establish a continuous quality improvement process for providing behavioral health home services.

(b) The behavioral health home services provider must also create a plan, in partnership with the individual and the individual's identified supports, to support the individual after discharge from a hospital, residential treatment program, or other setting. The plan must include protocols for:

(1) maintaining contact between the behavioral health home services team member, the individual, and the individual's identified supports during and after discharge;

(2) linking the individual to new resources as needed;

(3) reestablishing the individual's existing services and community and social supports; and

(4) following up with appropriate entities to transfer or obtain the individual's service records as necessary for continued care.

(c) If the individual is enrolled in a managed care plan, a behavioral health home services provider must:

(1) notify the behavioral health home services contact designated by the managed care plan within 30 days of when the individual begins behavioral health home services; and

(2) adhere to the managed care plan communication and coordination requirements described in the behavioral health home services manual.

(d) Before terminating behavioral health home services, the behavioral health home services provider must:

(1) provide a 60-day notice of termination of behavioral health home services to all individuals receiving behavioral health home services, the commissioner, and managed care plans, if applicable; and

(2) refer individuals receiving behavioral health home services to a new behavioral health home services provider.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 66. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4e. **Behavioral health home provider variances.** (a) The commissioner may grant a variance to specific requirements under subdivisions 4a, 4b, 4c, or 4d for a behavioral health home services provider according to this subdivision.

(b) The commissioner may grant a variance if the commissioner finds that:

(1) failure to grant the variance would result in hardship or injustice to the applicant;

(2) the variance would be consistent with the public interest; and

(3) the variance would not reduce the level of services provided to individuals served by the organization.

(c) The commissioner may grant a variance from one or more requirements to permit an applicant to offer behavioral health home services of a type or in a manner that is innovative, if the commissioner finds that the variance does not impede the achievement of the criteria in subdivisions 4a, 4b, 4c, or 4d and may improve the behavioral health home services provided by the applicant.

(d) The commissioner's decision to grant or deny a variance request is final and not subject to appeal.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 67. **[256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical assistance demonstration project to test reforms of Minnesota's substance use disorder treatment system to ensure individuals with substance use disorders have access to a full continuum of high quality care.

Subd. 2. **Provider participation.** Substance use disorder treatment providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider.

Subd. 3. **Provider standards.** (a) The commissioner shall establish requirements for participating providers that are consistent with the federal requirements of the demonstration project.

(b) A participating residential provider must obtain applicable licensure under chapters 245F and 245G or other applicable standards for the services provided and must:

(1) deliver services in accordance with standards published by the commissioner pursuant to paragraph (d);

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards; and

(3) provide or arrange for medication-assisted treatment services if requested by a client for whom an effective medication exists.

(c) A participating outpatient provider must obtain applicable licensure under chapter 245G or other applicable standards for the services provided and must:

(1) deliver services in accordance with standards published by the commissioner pursuant to paragraph (d); and

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards.

(d) If the provider standards under chapter 245G or other applicable standards conflict or are duplicative, the commissioner may grant variances to the standards if the variances do not conflict with federal requirements. The commissioner shall publish service components, service standards, and staffing requirements for participating providers that are consistent with ASAM standards and federal requirements by October 1, 2020.

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care.

(b) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), provided on or after January 1, 2020, payment rates must be increased by 15 percent over the rates in effect on December 31, 2020.

(c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1), (6), (7), and (10), provided on or after January 1, 2021, payment rates must be increased by ten percent over the rates in effect on December 31, 2020.

Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement the demonstration project under this section and to receive federal financial participation.

Sec. 68. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), or (c).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual ~~receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive concurrent housing support payments if receiving licensed residential crisis stabilization services under section 256B.0624, subdivision 7.~~ lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 69. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision 2a, providers shall ensure that participants have at a minimum:

(1) food preparation and service for three nutritional meals a day on site;

(2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

(3) housekeeping, including cleaning and lavatory supplies or service; and

(4) maintenance and operation of the building and grounds, including heat, water, garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair and maintain equipment and facilities.

(b) In addition, when providers serve participants described in subdivision 1, paragraph (c), the providers are required to assist the participants in applying for continuing housing support payments before the end of the eligibility period.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 70. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

(c) For an individual who receives ~~licensed residential crisis stabilization services under section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 71. Minnesota Statutes 2018, section 256K.45, subdivision 2, is amended to read:

Subd. 2. **Homeless youth report.** The commissioner shall prepare a biennial report, beginning in February 2015, which provides meaningful information to the legislative committees having jurisdiction over the issue of homeless youth, that includes, but is not limited to: (1) a list of the areas of the state with the greatest need for services and housing for homeless youth, and the level and nature of the needs identified; (2) details about grants made, including shelter-linked youth mental health grants under section 256K.46; (3) the distribution of funds throughout the state based on population need; (4) follow-up information, if available, on the status of homeless youth and whether they have stable housing two years after services are provided; and (5) any other outcomes for populations served to determine the effectiveness of the programs and use of funding.

Sec. 72. **[256K.46] SHELTER-LINKED YOUTH MENTAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment and authority.** (a) The commissioner shall award grants to provide mental health services to homeless or sexually exploited youth. To be eligible,

housing providers must partner with community-based mental health practitioners to provide a continuum of mental health services, including short-term crisis response, support for youth in longer-term housing settings, and ongoing relationships to support youth in other housing arrangements in the community for homeless or sexually exploited youth.

(b) The commissioner shall consult with the commissioner of management and budget to identify evidence-based mental health services for youth and give priority in awarding grants to proposals that include evidence-based mental health services for youth.

(c) The commissioner may make two-year grants under this section.

(d) Money appropriated for this section must be expended on activities described under subdivision 4, technical assistance, and capacity building to meet the greatest need on a statewide basis. The commissioner shall provide outreach, technical assistance, and program development support to increase capacity of new and existing service providers to better meet needs statewide, particularly in areas where shelter-linked youth mental health services have not been established, especially in greater Minnesota.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services, unless otherwise indicated.

(c) "Housing provider" means a shelter, housing program, or other entity providing services under the Homeless Youth Act in section 256K.45 and the Safe Harbor for Sexually Exploited Youth Act in section 145.4716.

(d) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17.

(e) "Youth" has the meanings given for "homeless youth," "youth at risk for homelessness," and "runaway" in section 256K.45, subdivision 1a, "sexually exploited youth" in section 260C.007, subdivision 31, and "youth eligible for services" in section 145.4716, subdivision 3.

Subd. 3. **Eligibility.** An eligible applicant for shelter-linked youth mental health grants under subdivision 1 is a housing provider that:

(1) demonstrates that the provider received targeted trauma training focused on sexual exploitation and adolescent experiences of homelessness; and

(2) partners with a community-based mental health practitioner who has demonstrated experience or access to training regarding adolescent development and trauma-informed responses.

Subd. 4. **Allowable grant activities.** (a) Grant recipients may conduct the following activities with community-based mental health practitioners:

(1) develop programming to prepare youth to receive mental health services;

(2) provide on-site mental health services, including group skills and therapy sessions. Grant recipients are encouraged to use evidence-based mental health services;

(3) provide mental health case management, as defined in section 256B.0625, subdivision 20; and

(4) consult, train, and educate housing provider staff regarding mental health. Grant recipients are encouraged to provide staff with access to a mental health crisis line 24 hours a day, seven days a week.

(b) Only after promoting and assisting participants with obtaining health insurance coverage for which the participant is eligible, and only after mental health practitioners bill covered services to medical assistance or health plan companies, grant recipients may use grant funds to fill gaps in insurance coverage for mental health services.

(c) Grant funds may be used for purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees to deliver shelter-linked youth mental health services defined in this subdivision via telemedicine consistent with section 256B.0625, subdivision 3b.

Subd. 5. **Reporting.** Grant recipients shall report annually on the use of shelter-linked youth mental health grants to the commissioner by December 31, beginning in 2020. Each report shall include the name and location of the grant recipient, the amount of each grant, the youth mental health services provided, and the number of youth receiving services. The commissioner shall determine the form required for the reports and may specify additional reporting requirements. The commissioner shall include the shelter-linked youth mental health services program in the biennial report required under section 256K.45, subdivision 2.

Sec. 73. Minnesota Statutes 2018, section 641.15, subdivision 3a, is amended to read:

Subd. 3a. **Intake procedure; approved mental health screening.** (a) As part of its intake procedure for new ~~prisoners~~ inmates, the sheriff or local corrections shall use a mental

health screening tool approved by the commissioner of corrections in consultation with the commissioner of human services and local corrections staff to identify persons who may have mental illness.

(b) Names of persons who have screened positive or may have a mental illness may be shared with the local county social services agency. The jail may refer an offender to county personnel of the welfare system, as defined in section 13.46, subdivision 1, paragraph (c), in order to arrange for services upon discharge and may share private data on the offender as necessary to:

(1) provide assistance in filling out an application for medical assistance or MinnesotaCare;

(2) make a referral for case management as provided under section 245.467, subdivision 4;

(3) provide assistance in obtaining a state photo identification;

(4) secure a timely appointment with a psychiatrist or other appropriate community mental health provider;

(5) provide prescriptions for a 30-day supply of all necessary medications; or

(6) coordinate behavioral health services.

(c) Notwithstanding section 138.17, if an offender is referred to a government entity within the welfare system pursuant to paragraph (b), and the offender refuses all services from the entity, the entity must, within 15 days of the refusal, destroy all private data on the offender that it created or received because of the referral.

Sec. 74. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective date, as amended by Laws 2019, chapter 12, section 1, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, ~~through June 30, 2019, and expires July 1, 2019~~ and thereafter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 75. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective date, as amended by Laws 2019, chapter 12, section 2, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, ~~through June 30, 2019, and expires July 1, 2019~~ and thereafter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 76. **DIRECTION TO COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT PROGRAM SYSTEMS IMPROVEMENT.**

The commissioner of human services, in consultation with counties, tribes, managed care organizations, substance use disorder treatment associations, and other relevant stakeholders, shall develop a plan, proposed timeline, and summary of necessary resources to make systems improvements to minimize the regulatory paperwork for substance use disorder programs licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes, chapters 245F and 245G, and Minnesota Rules, parts 2960.0580 to 2960.0700. The plan shall include procedures to ensure that continued input from all stakeholders is considered and that the planned systems improvements maximize client benefits and utility for providers, regulatory agencies, and payers.

Sec. 77. **COMMUNITY COMPETENCY RESTORATION TASK FORCE.**

Subdivision 1. **Establishment; purpose.** The Community Competency Restoration Task Force is established to evaluate and study community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial.

Subd. 2. **Membership.** (a) The Community Competency Restoration Task Force consists of the following members, appointed as follows:

(1) a representative appointed by the governor's office;

(2) the commissioner of human services or designee;

(3) the commissioner of corrections or designee;

(4) a representative from direct care and treatment services with experience in competency evaluations, appointed by the commissioner of human services;

(5) a representative appointed by the designated State Protection and Advocacy system;

(6) the ombudsman for mental health and developmental disabilities;

(7) a representative appointed by the Minnesota Hospital Association;

(8) a representative appointed by the Association of Minnesota Counties;

(9) two representatives appointed by the Minnesota Association of County Social Service Administrators: one from the seven-county metropolitan area, as defined under Minnesota

Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan area;

(10) a representative appointed by the Minnesota Board of Public Defense;

(11) a representative appointed by the Minnesota County Attorneys Association;

(12) a representative appointed by the Minnesota Chiefs of Police Association;

(13) a representative appointed by the Minnesota Psychiatric Society;

(14) a representative appointed by the Minnesota Psychological Association;

(15) a representative appointed by the State Court Administrator;

(16) a representative appointed by the Minnesota Association of Community Mental Health Programs;

(17) a representative appointed by the Minnesota Sheriffs' Association;

(18) a representative appointed by the Minnesota Sentencing Guidelines Commission;

(19) a jail administrator appointed by the commissioner of corrections;

(20) a representative from an organization providing reentry services appointed by the commissioner of corrections;

(21) a representative from a mental health advocacy organization appointed by the commissioner of human services;

(22) a person with direct experience with competency restoration appointed by the commissioner of human services;

(23) representatives from organizations representing racial and ethnic groups overrepresented in the justice system appointed by the commissioner of corrections; and

(24) a crime victim appointed by the commissioner of corrections.

(b) Appointments to the task force must be made no later than July 15, 2019, and members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 3. **Duties.** The task force must:

(1) identify current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;

(2) analyze current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;

(3) analyze selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;

(4) research how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and

(5) develop recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

Subd. 4. **Officers; meetings.** (a) The commissioner of human services shall convene the first meeting of the task force no later than August 1, 2019.

(b) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary.

(c) The task force is subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. **Staff.** (a) The commissioner of human services must provide staff assistance to support the task force's work.

(b) The task force may utilize the expertise of the Council of State Governments Justice Center.

Subd. 6. **Report required.** (a) By February 1, 2020, the task force shall submit a report on its progress and findings to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

(b) By February 1, 2021, the task force must submit a written report including recommendations to address the growing number of individuals deemed incompetent to stand trial to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision 6, paragraph (b), or February 1, 2021, whichever is later.

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

Sec. 78. **DIRECTION TO COMMISSIONER; IMPROVING SCHOOL-LINKED MENTAL HEALTH GRANT PROGRAM.**

(a) The commissioner of human services, in collaboration with the commissioner of education, representatives from the education community, mental health providers, and advocates, shall assess the school-linked mental health grant program under Minnesota Statutes, section 245.4901, and develop recommendations for improvements. The assessment must include but is not limited to the following:

(1) promoting stability among current grantees and school partners;

(2) assessing the minimum number of full-time equivalents needed per school site to effectively carry out the program;

(3) developing a funding formula that promotes sustainability and consistency across grant cycles;

(4) reviewing current data collection and evaluation; and

(5) analyzing the impact on outcomes when a school has a school-linked mental health program, a multi-tier system of supports, and sufficient school support personnel to meet the needs of students.

(b) The commissioner shall provide a report of the findings of the assessment and recommendations, including any necessary statutory changes, to the legislative committees with jurisdiction over mental health and education by January 15, 2020.

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

Sec. 79. **DIRECTION TO COMMISSIONER; CCBHC RATE METHODOLOGY.**

(a) The commissioner of human services shall develop recommendations for a rate methodology that reflects each CCBHC's reasonable cost of providing the services described in Minnesota Statutes, section 245.735, subdivision 3, consistent with applicable federal requirements. In developing the rate methodology, the commissioner shall consider guidance issued by the Centers for Medicare and Medicaid Services for the Section 223 Demonstration Program for CCBHC and costs associated with the following:

(1) a new CCBHC service that is not incorporated in the baseline prospective payment system rate, or a deletion of a CCBHC service that is incorporated in the baseline rate;

(2) a change in service due to amended regulatory requirements or rules;

(3) a change in types of services due to a change in applicable technology and medical practice utilized by the clinic;

(4) a change in the scope of a project approved by the commissioner; and

(5) a Minnesota-specific quality incentive program for CCBHCs that achieve target performance on select quality measures. The commissioner shall develop the quality incentive program, in consultation with stakeholders, with the following requirements:

(i) the same terms of performance must apply to all CCBHCs;

(ii) quality payments must be in addition to the prospective payment rate and must not exceed an amount equal to five percent of total medical assistance payments for CCBHC services provided during the applicable time period; and

(iii) the quality measures must be consistent with measures used by the commissioner for other health care programs.

(b) By February 15, 2020, the commissioner of human services shall consult with CCBHC providers to develop the rate methodology under paragraph (a). The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health services and medical assistance on the recommendations to the CCBHC rate methodology including any necessary statutory updates required for federal approval.

(c) The commissioner shall consult with CCBHCs and other providers receiving a prospective payment system rate to study a rate methodology that eliminates potential duplication of payment for CCBHC providers who also receive a separate prospective payment system rate. By February 15, 2021, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health services and medical assistance on findings and recommendations related to the rate methodology study under this paragraph, including any necessary statutory updates to implement recommendations.

Sec. 80. **SPECIALIZED MENTAL HEALTH COMMUNITY SUPERVISION PILOT PROJECT.**

Subdivision 1. **Authorization.** The commissioner of human services shall award a grant to Anoka County to develop and implement a pilot project from July 1, 2019, to June 30, 2021, to evaluate the impact of a coordinated, multidisciplinary service delivery approach for offenders with mental illness who are on probation, parole, supervised release, or pretrial status in Anoka County.

Subd. 2. **Pilot project goals and design.** (a) The pilot project must provide enhanced assessment, case management, treatment services, and community supervision for offenders with mental illness who have symptoms or behavior resulting in heightened risk to harm themselves or others, to recidivate, to commit violations of supervision, or to face incarceration or reincarceration.

(b) The goals of the pilot project are to:

(1) improve mental health service delivery and supervision coordination through establishment of a multidisciplinary caseload management team that must include at least one probation officer and social services professional who share case management responsibilities;

(2) provide expedited assessment, diagnosis, and community-based treatment and programming for acute symptom and behavior management;

(3) enhance community supervision through a specialized caseload and team specifically trained to work with individuals with mental illness;

(4) offer community-based mental health treatment and programming alternatives to incarceration if available and appropriate;

(5) reduce incarceration related to unmanaged mental illness and technical violations;

(6) eliminate or reduce duplication of services between county social services and corrections; and

(7) improve collaboration among, and reduce barriers between, criminal justice system partners, county social services, and community service providers.

Subd. 3. **Target population.** The target population of the pilot project is:

(1) adult offenders on probation, parole, supervised release, or pretrial status in Anoka County who have been assessed with significant or unmanaged mental illness or acute symptoms that pose a risk to harm themselves or others, or increase their risk to recidivate or commit technical violations of supervision;

(2) adult offenders who receive county social service case management for mental illness while under correctional supervision in Anoka County; and

(3) adult offenders incarcerated in jail in Anoka County who have significant or unmanaged mental illness and may be safely treated in a community setting under correctional supervision.

Subd. 4. **Evaluation and report.** By October 1, 2021, Anoka County must report to the commissioner of human services on the impact and outcomes of the project.

Sec. 81. **REPEALER.**

Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

ARTICLE 7
HEALTH CARE

Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data necessary for enforcement of sections 169.345 and 169.346 may be released to parking enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the judicial branch for purposes of debt collection, and the Department of Natural Resources for purposes of license application administration, and except that the last four digits of the Social Security number must be provided to the Department of Human Services for purposes of recovery of Minnesota health care program benefits paid; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 2. Minnesota Statutes 2018, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed $48,000,000, the amount in fiscal year 2017 shall not exceed $122,000,000, and the amount in any fiscal biennium thereafter shall not exceed $244,000,000. The purpose of this transfer is to meet the rate increase required under ~~Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6~~ section 256B.04, subdivision 25.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

Sec. 3. Minnesota Statutes 2018, section 62Q.184, subdivision 1, is amended to read:

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

(b) "Clinical practice guideline" means a systematically developed statement to assist health care providers and enrollees in making decisions about appropriate health care services for specific clinical circumstances and conditions developed independently of a health plan company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical practice guideline also includes a preferred drug list developed in accordance with section 256B.0625.

(c) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health plan company to determine the medical necessity and appropriateness of health care services.

(d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but ~~does not include a managed care organization or~~ also includes a county-based purchasing plan participating in a public program under chapter 256B or 256L~~, or~~ and an integrated health partnership under section 256B.0755.

(e) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, including self-administered and physician-administered drugs, are medically appropriate for a particular enrollee and are covered under a health plan.

(f) "Step therapy override" means that the step therapy protocol is overridden in favor of coverage of the selected prescription drug of the prescribing health care provider because at least one of the conditions of subdivision 3, paragraph (a), exists.

Sec. 4. Minnesota Statutes 2018, section 62Q.184, subdivision 3, is amended to read:

Subd. 3. **Step therapy override process; transparency.** (a) When coverage of a prescription drug for the treatment of a medical condition is restricted for use by a health plan company through the use of a step therapy protocol, enrollees and prescribing health care providers shall have access to a clear, readily accessible, and convenient process to request a step therapy override. The process shall be made easily accessible on the health plan company's website. A health plan company may use its existing medical exceptions process to satisfy this requirement. A health plan company shall grant an override to the step therapy protocol if at least one of the following conditions exist:

(1) the prescription drug required under the step therapy protocol is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:

(i) cause an adverse reaction to the enrollee;

(ii) decrease the ability of the enrollee to achieve or maintain reasonable functional ability in performing daily activities; or

(iii) cause physical or mental harm to the enrollee;

(2) the enrollee has had a trial of the required prescription drug covered by their current or previous health plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and was adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and the prescription drug was discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse event. This clause does not prohibit a health plan company from requiring an enrollee to try another drug in the same pharmacologic class or with the same mechanism of action if that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information. This clause does not apply to the commissioner of human services or a managed care plan, county-based purchasing plan, or integrated health partnership administering a pharmacy benefit under chapter 256B or 256L; ~~or~~

(3) for the fee-for-service system administered by the commissioner of human services, or a managed care plan, county-based purchasing plan, or integrated health partnership administering a pharmacy benefit under chapter 256B or 256L, the enrollee has had a trial of the required prescription drug covered by their current or previous health plan, or a drug in the same pharmacological class with the same mechanism of action, and was adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and the prescription drug was discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse event, or the prescriber submits an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested drug over the required prescription drug. This clause does not prohibit a managed care plan, county-based purchasing plan, or integrated health partnership from requiring an enrollee to try another drug in the same pharmacologic class with the same mechanism of action if that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information; or

~~(3)~~ (4) the enrollee is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current health plan or the immediately preceding health plan, the enrollee received coverage for the prescription drug and the enrollee's prescribing health care provider gives documentation to the health plan company that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the enrollee based on the known characteristics of the specific enrollee and the known characteristics of the required prescription drug.

(b) Upon granting a step therapy override, a health plan company shall authorize coverage for the prescription drug if the prescription drug is a covered prescription drug under the enrollee's health plan.

(c) The enrollee, or the prescribing health care provider if designated by the enrollee, may appeal the denial of a step therapy override by a health plan company using the complaint procedure under sections 62Q.68 to 62Q.73 or 256.045.

(d) In a denial of an override request and any subsequent appeal, a health plan company's decision must specifically state why the step therapy override request did not meet the condition under paragraph (a) cited by the prescribing health care provider in requesting the step therapy override and information regarding the procedure to request external review of the denial pursuant to section 62Q.73. A denial of a request for a step therapy override that is upheld on appeal is a final adverse determination for purposes of section 62Q.73 and is eligible for a request for external review by an enrollee pursuant to section 62Q.73.

(e) A health plan company shall respond to a step therapy override request or an appeal within five days of receipt of a complete request. In cases where exigent circumstances exist, a health plan company shall respond within 72 hours of receipt of a complete request. If a health plan company does not send a response to the enrollee or prescribing health care provider if designated by the enrollee within the time allotted, the override request or appeal is granted and binding on the health plan company.

(f) Step therapy override requests must be accessible to and submitted by health care providers, and accepted by group purchasers electronically through secure electronic transmission, as described under section 62J.497, subdivision 5.

(g) Nothing in this section prohibits a health plan company from:

(1) requesting relevant documentation from an enrollee's medical record in support of a step therapy override request; or

(2) requiring an enrollee to try a generic equivalent drug pursuant to section 151.21, or a biosimilar, as defined under United States Code, chapter 42, section 262(i)(2), prior to providing coverage for the equivalent branded prescription drug.

(h) This section shall not be construed to allow the use of a pharmaceutical sample for the primary purpose of meeting the requirements for a step therapy override.

Sec. 5. Minnesota Statutes 2018, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a program or service provider licensed under this chapter and the following individuals, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) the individual designated as the authorized agent under section 245A.04, subdivision 1, paragraph (b);

(3) the individual designated as the compliance officer under section 256B.04, subdivision 21, paragraph ~~(b)~~ (g); and

(4) each managerial official whose responsibilities include the direction of the management or policies of a program.

(b) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) an individual who is a state or federal official, or state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more programs, unless the individual is also an officer, owner, or managerial official of the program, receives remuneration from the program, or owns any of the beneficial interests not excluded in this subdivision;

(3) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2);

(4) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the program or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation; or

(5) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual according to paragraph (a).

(c) For purposes of this subdivision, "managerial official" means an individual who has the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 6. Minnesota Statutes 2018, section 245D.081, subdivision 3, is amended to read:

Subd. 3. **Program management and oversight.** (a) The license holder must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The designated manager is responsible for the following:

(1) maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph ~~(b)~~ (g);

(2) ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;

(3) ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports according to the requirements in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of alleged or suspected maltreatment must be conducted according to the requirements in section 245A.65, subdivision 1, paragraph (b);

(4) evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress ~~towards~~ toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and protecting each person's rights as identified in section 245D.04;

(5) ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

(6) ensuring corrective action is taken when ordered by the commissioner and that the terms and conditions of the license and any variances are met; and

(7) evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience in a program providing direct support services to persons with disabilities or persons age 65 and older.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 256.043, as added by Laws 2019, chapter 63, article 1, section 8, is amended to read:

256.043 OPIATE EPIDEMIC RESPONSE ACCOUNT.

Subdivision 1. **Establishment.** The opiate epidemic response account is established in the special revenue fund in the state treasury. The registration fees assessed by the Board of Pharmacy under section 151.066 and the license fees identified in section 151.065, subdivision 7, paragraphs (b) and (c), shall be deposited into the account. Beginning in fiscal year 2021, for each fiscal year, the funds in the account ~~are appropriated each fiscal year to the commissioner of human services, unless otherwise specified in law~~ shall be administered according to this section.

Subd. 2. **Transfers from account to state agencies.** (a) ~~Beginning in fiscal year 2021,~~ The commissioner ~~of human services~~ shall transfer the following amounts ~~each fiscal year from the account~~ to the agencies specified in this subdivision.

(b) $126,000 to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(c) $672,000 to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

Subd. 3. **Appropriations from account.** (a) After the transfers described in subdivision 2, and the appropriations in article 3, section 1, paragraphs (e), (f), (g), and (h) are made, $249,000 ~~shall be allocated by the commissioner~~ is appropriated for the provision of

administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (c).

(b) After the transfers in subdivision 2 and the ~~allocation of funds~~ appropriations in paragraph (a) are made, 50 percent of the remaining amount ~~shall be distributed by the commissioner to~~ is appropriated to the commissioner for distribution to county social service and tribal social service agencies to provide child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to counties and tribal social service agencies based on out-of-home placement episodes where parental drug abuse is the primary reason for the out-of-home placement using data from the previous calendar year. County and tribal social service agencies receiving funds from the opiate epidemic response account must annually report to the commissioner on how the funds were used to provide child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and tribal social service agencies must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

(c) After making the transfers in subdivision 2 and the ~~allocation of funds~~ appropriations in paragraphs (a) and (b), the remaining funds in the account are appropriated to the commissioner ~~shall~~ to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

Subd. 4. **Settlement; sunset.** (a) If the state receives a total sum of $250,000,000 either as a result of a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or resulting from a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency, against one or more opioid manufacturers or opioid wholesale drug distributors related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state, or other alleged illegal actions that contributed to the excessive use of opioids, or from the fees collected under section 151.065, subdivisions 1 and 3, and section 151.066, that are deposited into the opiate epidemic response account established in section 256.043, or from a combination of both, the fees specified in section 151.065, subdivision 1, clause (16), and section 151.065, subdivision 3, clause (14), shall be reduced to $5,260, and the opiate registration fee in section 151.066, subdivision 3, shall be repealed.

(b) The commissioner of management and budget shall inform the board of pharmacy, the governor, and the legislature when the amount specified in paragraph (a) has been reached. The board shall apply the reduced license fee for the next licensure period.

(c) Notwithstanding paragraph (a), the reduction of the license fee in section 151.065, subdivisions 1 and 3, and the repeal of the registration fee in section 151.066 shall not occur before July 1, 2024.

Sec. 8. Minnesota Statutes 2018, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations and licensed insurance producers under chapter 60K that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare or medical assistance, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a ~~$25~~ $70 application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, 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 rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, ~~through the next two rebasing periods~~ the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the

methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

Sec. 10. Minnesota Statutes 2018, 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~~ on a per claim basis, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. Services that have rates established under subdivision 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 30 days prior to implementation. The rate setting data must reflect the admissions data used to establish relative values. 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 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 or corresponding APR-DRGs, 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 or corresponding APR-DRGs, 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, 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 or corresponding APR-DRGs, 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 or corresponding APR-DRGs, 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 or corresponding APR-DRGs, 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.

(j) Effective for discharges on and after November 1, 2014, from hospitals paid under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision must be incorporated into the rebased rates established under subdivision 2b, paragraph (c), and must not be applied to each claim.

(k) Effective for discharges on and after July 1, 2015, from hospitals paid under subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

(l) Effective for discharges on and after July 1, 2017, from hospitals paid under subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

Sec. 11. Minnesota Statutes 2018, 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 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 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. 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) 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.

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

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received payment from the fee-for-service program for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than ~~three~~ two and one-half standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that has a medical assistance utilization rate in the base year that is at least ~~three~~ two and one-half standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(f) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed $1,500,000.

EFFECTIVE DATE. This section is effective July 1, 2019, except paragraph (f) is effective for discharges on or after July 1, 2019.

Sec. 12. Minnesota Statutes 2018, 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 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. 13. Minnesota Statutes 2018, section 256.969, subdivision 19, is amended to read:

Subd. 19. **Metabolic disorder testing of medical assistance recipients.** Medical assistance inpatient payment rates must include the cost incurred by hospitals to pay the Department of Health for metabolic disorder testing of newborns who are medical assistance recipients, if the cost is not recognized by another payment source. This payment increase remains in effect until the increase is fully recognized in the base year cost under subdivision 2b.

Sec. 14. Minnesota Statutes 2018, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation ~~for special transportation services~~ under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

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

Sec. 15. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E. A provider must enroll each provider-controlled location where direct services are provided. The commissioner may deny a provider's incomplete application if a provider fails to respond to the commissioner's request for additional information within 60 days of the request. The commissioner must conduct a background study under chapter 245C, including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider described in this paragraph. The background study requirement may be satisfied if the commissioner conducted a fingerprint-based background study on the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

(b) The commissioner shall revalidate each: (1) provider under this subdivision at least once every five years; and (2) personal care assistance agency under this subdivision once every three years.

(c) The commissioner shall conduct revalidation as follows:

(1) provide 30-day notice of the revalidation due date including instructions for revalidation and a list of materials the provider must submit;

(2) if a provider fails to submit all required materials by the due date, notify the provider of the deficiency within 30 days after the due date and allow the provider an additional 30 days from the notification date to comply; and

(3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day notice of termination and immediately suspend the provider's ability to bill. The provider does not have the right to appeal suspension of ability to bill.

(d) If a provider fails to comply with any individual provider requirement or condition of participation, the commissioner may suspend the provider's ability to bill until the provider comes into compliance. The commissioner's decision to suspend the provider is not subject to an administrative appeal.

(e) Correspondence and notifications, including notifications of termination and other actions, may be delivered electronically to a provider's MN-ITS mailbox. This paragraph does not apply to correspondences and notifications related to background studies.

(f) 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)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, 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)~~ (h) 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)~~ (i) 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)~~ (j) 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)~~ (k) 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)~~ (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3),

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. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety 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 surety 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 surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

~~(h)~~ (m) The Department of Human Services may require a provider to purchase a 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)~~ (f) and as per Code of Federal Regulations, title 42, section 455.450. The surety 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 surety 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. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 16. Minnesota Statutes 2018, section 256B.04, subdivision 22, is amended to read:

Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally required nonrefundable application fees to pay for provider screening activities in accordance with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application must be made under the procedures specified by the commissioner, in the form specified

by the commissioner, and accompanied by ~~an application~~ the fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. ~~Application~~ The fees must be deposited in the provider screening account in the special revenue fund. Amounts in the provider screening account are appropriated to the commissioner for costs associated with the provider screening activities required in Code of Federal Regulations, title 42, section 455, subpart E. ~~The commissioner shall conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise provided by law, to include database checks, unannounced pre- and postenrollment site visits, fingerprinting, and criminal background studies. The commissioner must revalidate all providers under this subdivision at least once every five years.~~

(b) The application fee under this subdivision is $532 for the calendar year 2013. For calendar year 2014 and subsequent years, the fee:

(1) is adjusted by the percentage change to the Consumer Price Index for all urban consumers, United States city average, for the 12-month period ending with June of the previous year. The resulting fee must be announced in the Federal Register;

(2) is effective from January 1 to December 31 of a calendar year;

(3) is required on the submission of an initial application, an application to establish a new practice location, an application for reenrollment when the provider is not enrolled at the time of application of reenrollment, or at revalidation when required by federal regulation; and

(4) must be in the amount in effect for the calendar year during which the application for enrollment, new practice location, or reenrollment is being submitted.

(c) The ~~application~~ fee under this subdivision cannot be charged to:

(1) providers who are enrolled in Medicare or who provide documentation of payment of the fee to, and enrollment with, another state, unless the commissioner is required to rescreen the provider;

(2) providers who are enrolled but are required to submit new applications for purposes of reenrollment;

(3) a provider who enrolls as an individual; and

(4) group practices and clinics that bill on behalf of individually enrolled providers within the practice who have reassigned their billing privileges to the group practice or clinic.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 17. Minnesota Statutes 2018, section 256B.04, is amended by adding a subdivision to read:

Subd. 25. **Medical assistance and MinnesotaCare payment increase.** (a) The commissioner shall increase medical assistance and MinnesotaCare fee-for-service payments by an amount equal to the tax rate defined for hospitals, surgical centers, or health care providers under sections 295.50 to 295.57 for all services subject to those taxes.

(b) The commissioner shall reflect in the total payments made to managed care organizations, county-based purchasing plans, and other participating entities contracted with the commissioner under section 256B.69, the cost of: (1) payments made to providers for the tax on the services outlined in paragraph (a); and (2) the taxes imposed under sections 297I.05, subdivision 5, and 256.9657, subdivision 3, on premium revenue paid by the state for medical assistance and the MinnesotaCare program. Any increase based on clause (2) must be reflected in provider rates paid by the managed care organization, county-based purchasing plan, or other participating entity, unless the managed care organization, county-based purchasing plan, or other participating entity is a staff model health plan company.

Sec. 18. Minnesota Statutes 2018, section 256B.055, subdivision 2, is amended to read:

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for Title IV-E of the Social Security Act but who is determined eligible for foster care or kinship assistance under chapter 256N.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2018, section 256B.056, subdivision 1, is amended to read:

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

(b) The commissioner shall identify individuals who are enrolled in medical assistance and who are absent from the state for more than 30 consecutive days, but who continue to qualify for medical assistance in accordance with paragraph (a).

(c) If the individual is absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota in accordance with paragraph (a), any covered service provided to the individual must be paid through the fee-for-service system and not through the managed care capitated rate payment system under section 256B.69 or 256L.12.

Sec. 20. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

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

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

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

(3) motor vehicles are excluded to the same extent excluded by the Supplemental Security Income program;

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

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

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

(6) ~~when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7.~~ a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person and the person's spouse in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059; and

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

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

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 256B.056, subdivision 5c, is amended to read:

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

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years shall equal:

(1) 81 percent of the federal poverty guidelines; and

(2) effective July 1, 2022, 100 percent of the federal poverty guidelines.

Sec. 22. Minnesota Statutes 2018, section 256B.056, subdivision 7a, is amended to read:

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

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

(c) An enrollee who is terminated for failure to complete the renewal process may subsequently submit the renewal form and required information within four months after the date of termination and have coverage reinstated without a lapse, if otherwise eligible under this chapter. The local agency may close the enrollee's case file if the required information is not submitted within four months of termination.

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

Sec. 23. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is

limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, ~~and~~ a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional, and a community health worker who meets the criteria under subdivision 49, paragraph (a); "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.

Sec. 24. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. ~~Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).~~

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

EFFECTIVE DATE. This section is effective July 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 25. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ~~actual acquisition~~ ingredient costs of the drugs ~~or the maximum allowable cost by the commissioner~~ plus the ~~fixed~~ professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee shall be ~~$3.65~~ $10.48 for ~~legend prescription drugs, except that~~ prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~ that must be compounded by the pharmacist shall be ~~$8~~ $10.48 per bag~~, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products~~

~~dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter~~. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.48 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65~~, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition~~ for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug ~~acquired through~~ for a provider participating in the federal 340B Drug Pricing Program shall be ~~estimated by the commissioner at wholesale acquisition cost minus 40 percent~~ either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to~~, but~~ the actual acquisition cost of the drug

product and no higher than~~, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs~~ the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) ~~An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a multisource drug, ~~payment shall be the lower of the usual and customary price charged to the public or~~ the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States

Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may ~~negotiate lower reimbursement~~ establish maximum allowable cost rates for specialty pharmacy products ~~than the rates~~ that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to ~~this paragraph~~ maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the ~~reimbursement rate~~ maximum allowable cost to prevent access to care issues.

(g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must

respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

(i) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

EFFECTIVE DATE. This section is effective July 1, 2019, or upon federal approval, whichever is later. Paragraph (i) expires if federal approval is denied. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained or denied.

Sec. 26. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.~~

~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required

to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

(f) Prior authorization under this subdivision shall comply with section 62Q.184.

EFFECTIVE DATE. This section is effective the day following final enactment, except that paragraph (f) is effective July 1, 2019.

Sec. 27. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and ~~in consultation with the Minnesota Department of Transportation~~ all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety

locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;

(4) $13 for the base rate and $1.30 per mile for assisted transport;

(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 28. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff to oversee providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 29. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the provider must be placed on a one-year probation period. During a provider's probation period the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

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

Sec. 30. Minnesota Statutes 2018, 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 (FQHC) 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~~ An FQHC 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~~ an FQHC 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~~ FQHCs 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~~ an FQHC 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~~ FQHCs 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~~ FQHCs 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~~ FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring ~~a federally qualified health center~~ an FQHC 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, through December 31, 2020, each ~~federally qualified health center~~ FQHC 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) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l).

(h) 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)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

~~(i)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

~~(j)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization

in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fund-raising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year;

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) For FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural

health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rate;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

Sec. 31. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers, Indian Health Services, and rural health clinics.

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

Sec. 32. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access

during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 33. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

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

(2) proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety 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 for each business location providing service;

(4) proof of workers' compensation insurance coverage identifying the business location where personal care assistance services are provided;

(5) proof of liability insurance coverage identifying the business location where personal care assistance services are provided and naming the department as a certificate holder;

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

~~(7)~~ (6) a copy of the personal care assistance provider agency'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)~~ (7) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

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

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

~~(11)~~ (10) documentation of the agency's marketing practices;

~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

~~(13)~~ (12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies 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 before submitting an application for enrollment of the agency as a provider. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. 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 personal care assistance provider agency 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. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. 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. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this

subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

(d) All surety bonds, fidelity bonds, workers compensation insurance, and liability insurance required by this subdivision must be maintained continuously. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

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

Sec. 34. Minnesota Statutes 2018, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; ~~and~~

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15; and

(10) persons who are absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision 1, paragraph (b).

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled

with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

Sec. 35. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision to read:

Subd. 31a. **Trend limit; calculation.** (a) Beginning January 1, 2020, and ending June 30, 2024, the commissioner of human services may, to the extent practicable, limit the year over year increase in rates paid to managed care plans and county-based purchasing plans under this section and section 256B.692 by an amount equal to the value of a 0.8 percent reduction in rates in medical assistance across all products. Managed care rates must meet actuarial soundness and rate development requirements under Code of Federal Regulations, title 42, part 438, subpart A. Forecast expenditure growth assumptions cannot be part of the rate-setting process.

(b) In the November 2019 forecast, the commissioner of human services, in consultation with the commissioner of management and budget, shall determine the extent to which the year over year change in managed care and county-based purchasing plan rates are forecasted to reduce medical assistance expenditures in fiscal years 2020 through 2024, relative to projected expenditures from the end of the 2019 legislative session that establish a budget for the Department of Human Services. To the extent the total value of the reduction is less than $145,150,000, the commissioner of management and budget shall transfer the difference from the premium security account established in section 62E.25, subdivision 1, to the general fund.

Sec. 36. **[256B.758] REIMBURSEMENT FOR DOULA SERVICES.**

Effective for services provided on or after July 1, 2019, payments for doula services provided by a certified doula shall be $47 per prenatal or postpartum visit and $488 for attending and providing doula services at a birth.

Sec. 37. Minnesota Statutes 2018, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under paragraphs (i) and (j).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

(i) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

(j) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid

that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in paragraph (i). Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this paragraph.

(k) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For payments made in accordance with this paragraph, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this paragraph.

(l) Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2019, subject to federal approval. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 38. Minnesota Statutes 2018, section 256B.79, subdivision 2, is amended to read:

Subd. 2. **~~Pilot~~ Grant program established.** The commissioner shall implement a ~~pilot~~ grant program to improve birth outcomes and strengthen early parental resilience for pregnant women who are medical assistance enrollees, are at significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations. The program must promote the provision of integrated care and enhanced services to these pregnant women, including postpartum coordination to ensure ongoing continuity of care, by qualified integrated perinatal care collaboratives.

Sec. 39. Minnesota Statutes 2018, section 256B.79, subdivision 3, is amended to read:

Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. ~~Grants must be awarded beginning July 1, 2016.~~ Grant funds must be distributed through a request for proposals process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or within an entity in the process of meeting the qualifications to become a qualified integrated perinatal care collaborative, and priority shall be given to qualified integrated perinatal care collaboratives that received grants under this section prior to January 1, 2019. Grant awards must be used to support interdisciplinary, team-based needs assessments, planning, and implementation of integrated care and enhanced services for targeted populations. In determining grant award amounts, the commissioner shall consider the identified health and social risks linked to adverse outcomes and attributed to enrollees within the identified targeted population.

Sec. 40. Minnesota Statutes 2018, section 256B.79, subdivision 4, is amended to read:

Subd. 4. **Eligibility for grants.** To be eligible for a grant under this section, an entity must ~~show that the entity meets or is in the process of meeting~~ meet qualifications established by the commissioner to be a qualified integrated perinatal care collaborative. These qualifications must include evidence that the entity has ~~or is in the process of developing~~ policies, services, and partnerships to support interdisciplinary, integrated care. The policies, services, and partnerships must meet specific criteria and be approved by the commissioner. The commissioner shall ~~establish a process to~~ review the collaborative's capacity for interdisciplinary, integrated care, to be reviewed at the commissioner's discretion. In determining whether the entity meets the qualifications for a qualified integrated perinatal care collaborative, the commissioner shall verify and review whether the entity's policies, services, and partnerships:

(1) optimize early identification of drug and alcohol dependency and abuse during pregnancy, effectively coordinate referrals and follow-up of identified patients to evidence-based or evidence-informed treatment, and integrate perinatal care services with behavioral health and substance abuse services;

(2) enhance access to, and effective use of, needed health care or tribal health care services, public health or tribal public health services, social services, mental health services, chemical dependency services, or services provided by community-based providers by bridging cultural gaps within systems of care and by integrating community-based

paraprofessionals such as doulas and community health workers as routinely available service components;

(3) encourage patient education about prenatal care, birthing, and postpartum care, and document how patient education is provided. Patient education may include information on nutrition, reproductive life planning, breastfeeding, and parenting;

(4) integrate child welfare case planning with substance abuse treatment planning and monitoring, as appropriate;

(5) effectively systematize screening, collaborative care planning, referrals, and follow up for behavioral and social risks known to be associated with adverse outcomes and known to be prevalent within the targeted populations;

(6) facilitate ongoing continuity of care to include postpartum coordination and referrals for interconception care, continued treatment for substance abuse, identification and referrals for maternal depression and other chronic mental health conditions, continued medication management for chronic diseases, and appropriate referrals to tribal or county-based social services agencies and tribal or county-based public health nursing services; and

(7) implement ongoing quality improvement activities as determined by the commissioner, including collection and use of data from qualified providers on metrics of quality such as health outcomes and processes of care, and the use of other data that has been collected by the commissioner.

Sec. 41. Minnesota Statutes 2018, section 256B.79, subdivision 5, is amended to read:

Subd. 5. **Gaps in communication, support, and care.** A collaborative receiving a grant under this section must ~~develop means of identifying and reporting~~ identify and report gaps in the collaborative's communication, administrative support, and direct care, if any, that must be remedied for the collaborative to continue to effectively provide integrated care and enhanced services to targeted populations.

Sec. 42. Minnesota Statutes 2018, section 256B.79, subdivision 6, is amended to read:

Subd. 6. **Report.** By January 31, ~~2019~~ 2021, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the status and ~~progress~~ outcomes of the ~~pilot~~ grant program. The report must:

(1) describe the capacity of collaboratives receiving grants under this section;

(2) contain aggregate information about enrollees served within targeted populations;

(3) describe the utilization of enhanced prenatal services;

(4) for enrollees identified with maternal substance use disorders, describe the utilization of substance use treatment and dispositions of any child protection cases;

(5) contain data on outcomes within targeted populations and compare these outcomes to outcomes statewide, using standard categories of race and ethnicity; and

(6) include recommendations for continuing the program or sustaining improvements through other means ~~beyond June 30, 2019~~.

Sec. 43. Minnesota Statutes 2018, section 256L.11, subdivision 2, is amended to read:

Subd. 2. **Payment of certain providers.** Services provided by federally qualified health centers, rural health clinics, ~~and~~ facilities of the Indian health service, and certified community behavioral health clinics shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, ~~or~~ facilities of the Indian health service, or certified community behavioral health clinics. The alternative payment methodology described under section 256B.0625, subdivision 30, paragraph (l), shall not apply to services delivered under this chapter by federally qualified health centers, rural health clinics, and facilities of the Indian Health Services. The prospective payment system for certified behavioral health clinics under section 256B.0625, subdivision 5m, shall not apply to services delivered under this chapter.

Sec. 44. **STUDY OF CLINIC COSTS.**

The commissioner of human services shall conduct a five-year comparative analysis of the actual change in aggregate federally qualified health center (FQHC) and rural health clinic costs versus the CMS FQHC Market Basket inflator using 2017 through 2022 finalized Medicare Cost Reports, CMS 2224-14, and report the findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by July 1, 2025.

Sec. 45. **CORRECTIVE PLAN TO ELIMINATE DUPLICATE PERSONAL IDENTIFICATION NUMBERS.**

(a) The commissioner of human services shall design and implement a corrective plan to address the issue of medical assistance enrollees being assigned more than one personal

identification number. Any corrections or fixes that are necessary to address this issue are required to be completed by June 30, 2021.

(b) By February 15, 2020, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the progress of the corrective plan required in paragraph (a), including an update on meeting the June 30, 2021, deadline. The report must also include information on:

(1) the number of medical assistance enrollees who have been assigned two or more personal identification numbers;

(2) any possible financial effect of enrollees having duplicate personal identification numbers on health care providers and managed care organizations, including the effect on reimbursement rates, meeting withhold requirements, and capitated payments; and

(3) any effect on federal payments received by the state.

Sec. 46. **BLUE RIBBON COMMISSION ON HEALTH AND HUMAN SERVICES.**

Subdivision 1. **Establishment.** The commissioners of health and human services shall convene a Blue Ribbon Commission to advise and assist the legislature and governor in transforming the health and human services system to build greater efficiencies, savings, and better outcomes for Minnesotans.

Subd. 2. **Membership; appointment.** (a) The Blue Ribbon Commission consists of 17 members as follows:

(1) two members of the house of representatives appointed by the speaker of the house;

(2) two members of the senate appointed by the senate majority leader;

(3) the commissioner of human services or designee;

(4) the commissioner of health or designee;

(5) four members appointed by the governor who have demonstrated expertise and leadership in health care, long-term care, or social service organization, health and human services technology, or other collaborative health and human services system improvement activities with a history of providing guidance to state and local governments;

(6) two members appointed by the governor who have demonstrated leadership in employer and group purchaser activities in which the group purchaser is not a health plan company; one of the members appointed must be from a labor organization; and

(7) five members appointed by the governor who have demonstrated public or private leadership, cultural responsiveness, and innovation in the area of health and human services.

(b) The governor is exempt from the requirements of the open appointments process for purposes of appointing commission members.

Subd. 3. **Cochairs.** The commissioners of health and human services shall serve as cochairs of the commission. The commissioner of human services shall convene the first meeting.

Subd. 4. **Compensation; expenses; reimbursement.** Public members shall be compensated and reimbursed for expenses as provided in Minnesota Statutes, section 15.0575, subdivision 3.

Subd. 5. **Administrative support.** The commissioners of health and human services shall provide meeting space and administrative support to the commission.

Subd. 6. **Gifts.** The commission may accept gifts and grants on behalf of the state for the purpose of supporting the commission. Any such gifts or grants shall constitute donations to the state. Funds received under this subdivision are appropriated to the commissioner of human services to support the commission in performing its duties.

Subd. 7. **Public and stakeholder engagement.** The commissioners of health and human services shall review available research to determine Minnesotans' values, preferences, opinions, and perceptions related to human services and health care benefits and other issues that may be before the commission and shall present the findings to the commission.

Subd. 8. **Duties.** (a) By October 1, 2020, the commission shall develop and present to the legislature and the governor an action plan for transforming the health and human services system to improve program efficiencies, produce savings, and promote better outcomes for Minnesotans. The action plan must include, but is not limited to, the following:

(1) strategies to increase administrative efficiencies and improve program simplification within health and human services public programs, including examining the roles and experience of counties and tribes in delivering services and identifying any conflicting and duplicative roles and responsibilities among health and human services agencies, counties, and tribes;

(2) approaches to reducing health and human services expenditures, including identifying evidence-based strategies for addressing the significant cost drivers of state spending on health and human services, including the medical assistance program;

(3) opportunities for reducing fraud and improving program integrity in health and human services; and

(4) statewide strategies for improving access to health and human services with a focus on addressing geographic, racial, and ethnic disparities.

(b) The commission may contract with a private entity or consultant as necessary to complete its duties under this section, and shall be exempt from state procurement process requirements under Minnesota Statutes, chapter 16C.

Subd. 9. **Limitations.** (a) In developing the action plan, the commission shall take into consideration the impact of its recommendations on:

(1) the existing capacity of state agencies, including staffing needs, technology resources, and existing agency responsibilities; and

(2) the capacity of county and tribal partners.

(b) The commission shall not include in the action plan recommendations that may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to health care and human services.

Subd. 10. **Expiration.** The Blue Ribbon Commission expires October 2, 2020, or the day after submitting the action plan required under subdivision 8, whichever is earlier.

Sec. 47. **REPEALER.**

(a) Minnesota Statutes 2018, sections 256B.0625, subdivision 63; 256B.0659, subdivision 22; and 256L.11, subdivision 2a, are repealed.

(b) Minnesota Statutes 2018, sections 256B.0625, subdivision 31c; and 256B.79, subdivision 7, are repealed effective the day following final enactment.

ARTICLE 8
HEALTH COVERAGE

Section 1. Minnesota Statutes 2018, section 62A.30, is amended by adding a subdivision to read:

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

(1) having a family history with one or more first- or second-degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans issued, sold, or renewed on or after that date.

Sec. 2. **[62A.3097] PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS) TREATMENT; COVERAGE.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Pediatric acute-onset neuropsychiatric syndrome" means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

(c) "Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other

neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

Subd. 2. **Scope of coverage.** This section applies to all health plans that provide coverage to Minnesota residents.

Subd. 3. **Required coverage.** Every health plan included in subdivision 2 must provide coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments that must be covered under this section must be recommended by the insured's licensed health care professional and include but are not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Subd. 4. **Reimbursement.** The commissioner of commerce shall reimburse health carriers for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Each fiscal year an amount necessary to make payments to health carriers to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce. Health carriers shall report to the commissioner quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. The commissioner shall evaluate submissions and make payments to health carriers as provided in Code of Federal Regulations, title 45, section 155.170.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2018, section 62D.12, is amended by adding a subdivision to read:

Subd. 8a. **Net earnings.** All net earnings of a nonprofit health maintenance organization must be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. A nonprofit health maintenance organization must not provide for the payment, whether directly or indirectly, of any part of its net earnings to any person for a purpose other than providing comprehensive health care, except that the health maintenance organization may make payments to providers or other persons based on the efficient provision of services or as incentives to provide quality care. The commissioner of health shall, pursuant to this chapter, revoke the certificate of authority of any nonprofit health maintenance organization in violation of this subdivision.

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

Sec. 4. Minnesota Statutes 2018, section 62D.124, subdivision 3, is amended to read:

Subd. 3. **~~Exception~~ Waiver.** ~~The commissioner shall grant an exception to the requirements of this section according to Minnesota Rules, part 4685.1010, subpart 4, if the health maintenance organization can demonstrate with specific data that the requirement of subdivision 1 or 2 is not feasible in a particular service area or part of a service area.~~ (a) A health maintenance organization may apply to the commissioner of health for a waiver of the requirements in subdivision 1 or 2 if it is unable to meet those requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied by an application fee of $500 per county per year, for each application to waive the requirements in subdivision 1 or 2 for one or more provider types in that county, and must:

(1) demonstrate with specific data that the requirements of subdivision 1 or 2 are not feasible in a particular service area or part of a service area; and

(2) include specific information as to the steps that were and will be taken to address network inadequacy, and for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) Using the guidelines and standards established under section 62K.10, subdivision 5, paragraph (b), the commissioner shall review each waiver request and shall approve a waiver only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for implementing these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health maintenance organization demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health maintenance organization is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) A waiver shall automatically expire after three years. Upon or prior to expiration of a waiver, a health maintenance organization unable to meet the requirements in subdivision 1 or 2 must submit a new waiver application under paragraph (a) and must also submit evidence of steps the organization took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the organization for the most recent three-year period, the commissioner

shall also examine the steps the organization took during that three-year period to address network inadequacy, and shall only approve a subsequent waiver application if it satisfies the requirements in paragraph (b), demonstrates that the organization took the steps it proposed to address network inadequacy, and explains why the organization continues to be unable to satisfy the requirements in subdivision 1 or 2.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

EFFECTIVE DATE. This section is effective January 1, 2020, for health plans sold, issued, or renewed on or after January 1, 2021.

Sec. 5. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision to read:

Subd. 7. **Provider network notifications.** A health maintenance organization must provide on the organization's website the provider network for each product offered by the organization, and must update the organization's website at least once a month with any changes to the organization's provider network, including provider changes from in-network status to out-of-network status. A health maintenance organization must also provide on the organization's website, for each product offered by the organization, a list of the current waivers of the requirements in subdivision 1 or 2, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

Sec. 6. Minnesota Statutes 2018, section 62E.23, subdivision 3, is amended to read:

Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall approve or reject the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve or reject the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the amount in the premium security plan account in section 62E.25, subdivision 1, is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

(c) Notwithstanding paragraph (a), the payment parameters for benefit year 2020 are:

(1) an attachment point of $50,000;

(2) a coinsurance rate of 80 percent; and

(3) a reinsurance cap of $250,000.

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

Sec. 7. Minnesota Statutes 2018, section 62E.24, subdivision 2, is amended to read:

Subd. 2. **Reports.** (a) The board must submit to the commissioner and to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and make available to the public ~~a~~ quarterly reports on plan operations and an annual report summarizing the plan operations for each benefit year ~~by~~. All reports must be made public by posting the ~~summary~~ report on the Minnesota Comprehensive Health Association website ~~and making the~~. The annual summary ~~otherwise~~ must be made available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

(b) The reports must include information about:

(1) the reinsurance parameters used;

(2) the metal levels affected;

(3) the number of claims payments estimated and submitted for payment per products offered on-exchange and off-exchange and per eligible health carrier;

(4) the estimated reinsurance payments by plan type based on carrier submitted templates;

(5) funds appropriated for reinsurance payments and administrative and operational expenses for each year, including the federal and state contributions received, investment income, and any other revenue or funds received;

(6) the total amount of reinsurance payments made to each eligible health carrier; and

(7) administrative and operational expenses incurred for the plan, including the total amount incurred and as a percentage of the plan's operational budget.

Sec. 8. Minnesota Statutes 2018, section 62K.07, is amended to read:

62K.07 INFORMATION DISCLOSURES.

Subdivision 1. **In general.** (a) A health carrier offering individual or small group health plans must submit the following information in a format determined by the commissioner of commerce:

(1) claims payment policies and practices;

(2) periodic financial disclosures;

(3) data on enrollment;

(4) data on disenrollment;

(5) data on the number of claims that are denied;

(6) data on rating practices;

(7) information on cost-sharing and payments with respect to out-of-network coverage; and

(8) other information required by the secretary of the United States Department of Health and Human Services under the Affordable Care Act.

(b) A health carrier offering an individual or small group health plan must comply with all information disclosure requirements of all applicable state and federal law, including the Affordable Care Act.

(c) Except for qualified health plans sold on MNsure, information reported under paragraph (a), clauses (3) and (4), is nonpublic data as defined under section 13.02, subdivision 9. Information reported under paragraph (a), clauses (1) through (8), must be reported by MNsure for qualified health plans sold through MNsure.

Subd. 2. **Prescription drug costs.** (a) Each health carrier that offers a prescription drug benefit in its individual health plans or small group health plans shall include in the applicable rate filing required under section 62A.02 the following information about covered prescription drugs:

(1) the 25 most frequently prescribed drugs in the previous plan year;

(2) the 25 most costly prescription drugs as a portion of the individual health plan's or small group health plan's total annual expenditures in the previous plan year;

(3) the 25 prescription drugs that have caused the greatest increase in total individual health plan or small group health plan spending in the previous plan year;

(4) the projected impact of the cost of prescription drugs on premium rates;

(5) if any health plan offered by the health carrier requires enrollees to pay cost-sharing on any covered prescription drugs including deductibles, co-payments, or coinsurance in an amount that is greater than the amount the enrollee's health plan would pay for the drug absent the applicable enrollee cost-sharing and after accounting for any rebate amount; and

(6) if the health carrier prohibits third-party payments including manufacturer drug discounts or coupons that cover all or a portion of an enrollee's cost-sharing requirements including deductibles, co-payments, or coinsurance from applying toward the enrollee's cost-sharing obligations under the enrollee's health plan.

(b) The commissioner of commerce, in consultation with the commissioner of health, shall release a summary of the information reported in paragraph (a) at the same time as the information required under section 62A.02, subdivision 2, paragraph (c).

Subd. 3. **Enforcement.** ~~(d)~~ The commissioner of commerce shall enforce this section.

EFFECTIVE DATE. This section is effective for individual health plans and small group health plans offered, issued, sold, or renewed on or after January 1, 2021.

Sec. 9. Minnesota Statutes 2018, section 62K.075, is amended to read:

62K.075 PROVIDER NETWORK NOTIFICATIONS.

(a) A health carrier must provide on the carrier's website the provider network for each product offered by the carrier, and must update the carrier's website at least once a month with any changes to the carrier's provider network, including provider changes from in-network status to out-of-network status. A health carrier must also provide on the carrier's website, for each product offered by the carrier, a list of the current waivers of the requirements in section 62K.10, subdivision 2 or 3, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

(b) Upon notification from an enrollee, a health carrier must reprocess any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change was posted as required under paragraph (a) unless the health carrier notified the enrollee of the network change prior to the service being provided. This paragraph does not apply if the health carrier is able to verify that the health carrier's website displayed the correct provider network status on the health carrier's website at the time the service was provided.

(c) The limitations of section 62Q.56, subdivision 2a, shall apply to payments required by paragraph (b).

Sec. 10. Minnesota Statutes 2018, section 62K.10, subdivision 5, is amended to read:

Subd. 5. **Waiver.** (a) A health carrier ~~or preferred provider organization~~ may apply to the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied by an application fee of $500 for each application to waive the requirements in subdivision 2 or 3 for one or more provider types per county, and must:

(1) demonstrate with specific data that the requirement of subdivision 2 or 3 is not feasible in a particular service area or part of a service area; and

(2) include specific information as to the steps that were and will be taken to address the network inadequacy, and for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) The commissioner shall establish guidelines for evaluating waiver applications, standards governing approval or denial of a waiver application, and standards for steps that health carriers must take to address the network inadequacy and allow the health carrier to meet network adequacy requirements within a reasonable time period. The commissioner shall review each waiver application using these guidelines and standards and shall approve a waiver application only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for taking these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health carrier demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health carrier is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) The waiver shall automatically expire after ~~four years. If a renewal of the waiver is sought, the commissioner of health shall take into consideration steps that have been taken to address network adequacy.~~ one year. Upon or prior to expiration of a waiver, a health carrier unable to meet the requirements in subdivision 2 or 3 must submit a new waiver application under paragraph (a) and must also submit evidence of steps the carrier took to

address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the carrier for the most recent one-year period, the commissioner shall also examine the steps the carrier took during that one-year period to address network inadequacy, and shall only approve a subsequent waiver application that satisfies the requirements in paragraph (b), demonstrates that the carrier took the steps it proposed to address network inadequacy, and explains why the carrier continues to be unable to satisfy the requirements in subdivision 2 or 3.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

EFFECTIVE DATE. This section is effective January 1, 2020, for health plans sold, issued, or renewed on or after January 1, 2021.

Sec. 11. **[62K.105] NETWORK ADEQUACY COMPLAINTS.**

The commissioner of health shall establish a clear, easily accessible process for accepting complaints from enrollees regarding health carrier compliance with section 62K.10, subdivision 2, 3, or 4. Using this process, an enrollee may file a complaint with the commissioner that a health carrier is not in compliance with the requirements of section 62K.10, subdivision 2, 3, or 4. The commissioner of health shall investigate all complaints received under this section.

Sec. 12. Minnesota Statutes 2018, section 62Q.01, is amended by adding a subdivision to read:

Subd. 6b. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include but are not limited to:

(1) medical management standards limiting or excluding benefits based on (i) medical necessity or medical appropriateness, or (ii) whether the treatment is experimental or investigative;

(2) formulary design for prescription drugs;

(3) health plans with multiple network tiers;

(4) criteria and parameters for provider inclusion in provider networks, including credentialing standards and reimbursement rates;

(5) health plan methods for determining usual, customary, and reasonable charges;

(6) fail-first or step therapy protocols;

(7) exclusions based on failure to complete a course of treatment;

(8) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the health plan;

(9) in- and out-of-network geographic limitations;

(10) standards for providing access to out-of-network providers;

(11) limitations on inpatient services for situations where the enrollee is a threat to self or others;

(12) exclusions for court-ordered and involuntary holds;

(13) experimental treatment limitations;

(14) service coding;

(15) exclusions for services provided by clinical social workers; and

(16) provider reimbursement rates, including rates of reimbursement for mental health and substance use disorder services in primary care.

Sec. 13. **[62Q.1841] PROHIBITION ON USE OF STEP THERAPY FOR METASTATIC CANCER.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan" has the meaning given in section 62Q.01, subdivision 3. Health plan includes health coverage provided by a county-based purchasing plan participating in a public program under chapter 256B or 256L or an integrated health partnership under section 256B.0755.

(c) "Stage four advanced metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other parts of the body.

(d) "Step therapy protocol" has the meaning given in section 62Q.184, subdivision 1.

Subd. 2. **Prohibition on use of step therapy protocols.** A health plan that provides coverage for the treatment of stage four advanced metastatic cancer or associated conditions

must not limit or exclude coverage for a drug approved by the United States Food and Drug Administration that is on the health plan's prescription drug formulary by mandating that an enrollee with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

(1) a United States Food and Drug Administration-approved indication; and

(2) a clinical practice guideline published by the National Comprehensive Care Network.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 14. Minnesota Statutes 2018, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

~~(d)~~ (e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section and section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

Sec. 15. **[62Q.48] COST-SHARING IN PRESCRIPTION INSULIN DRUGS.**

Subdivision 1. **Scope of coverage.** This section applies to all health plans issued or renewed to a Minnesota resident.

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

(b) "Cost-sharing" means a deductible payment, co-payment, or coinsurance amount imposed on an enrollee for a covered prescription drug in accordance with the terms and conditions of the enrollee's health plan.

(c) "Legend drug" has the same meaning as in section 151.01, subdivision 17.

(d) "Prescription insulin drug" means a legend drug that contains insulin and is used to treat diabetes.

(e) "Net price" means the health plan company's cost for a prescription insulin drug, including any rebates or discounts received by or accrued directly or indirectly to the health plan company from a drug manufacturer or pharmacy benefit manager.

Subd. 3. **Cost-sharing limits.** (a) A health plan that imposes a cost-sharing requirement on the coverage of a prescription insulin drug shall limit the total amount of cost-sharing that an enrollee is required to pay at point of sale, including deductible payments and the cost-sharing amounts charged once the deductible is met at an amount that does not exceed the net price of the prescription insulin drug.

(b) Nothing in this section shall prevent a health plan company from imposing a cost-sharing requirement that is less than the amount specified in paragraph (a).

EFFECTIVE DATE. This section is effective for health plans issued or renewed on or after January 1, 2020.

Sec. 16. Minnesota Statutes 2018, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months thereafter, all health plan companies and third-party administrators shall submit encounter data to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home and, for claims incurred on or after January 1, 2019, data deemed necessary by the commissioner to uniquely identify claims in the individual health insurance market; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out the commissioner's responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the

commissioner and with established and emerging data quality standards to ensure data quality.

Sec. 17. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental

illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

(g) Any step therapy protocol requirements established by the commissioner must comply with section 62Q.1841.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 18. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).** Medical assistance covers treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS). Coverage shall be developed in collaboration with the Health Services Policy Committee established under subdivision 3c.

Sec. 19. Laws 2017, chapter 13, article 1, section 15, as amended by Laws 2017, First Special Session chapter 6, article 5, section 10, is amended to read:

Sec. 15. **MINNESOTA PREMIUM SECURITY PLAN FUNDING.**

(a) The Minnesota Comprehensive Health Association shall fund the operational and administrative costs and reinsurance payments of the Minnesota security plan and association using the following amounts deposited in the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1, in the following order:

(1) any federal funding available;

(2) funds deposited under article 1, sections 12 and 13;

(3) any state funds from the health care access fund; and

(4) any state funds from the general fund.

(b) The association shall transfer from the premium security plan account any remaining state funds not used for the Minnesota premium security plan by June 30, ~~2021~~ 2023, to the commissioner of commerce. Any amount transferred to the commissioner of commerce shall be deposited in the health care access fund in Minnesota Statutes, section 16A.724.

(c) The Minnesota Comprehensive Health Association may not spend more than $271,000,000 for benefit year 2018 and not more than $271,000,000 for benefit year 2019 for the operational and administrative costs of, and reinsurance payments under, the Minnesota premium security plan.

Sec. 20. Laws 2017, First Special Session chapter 6, article 5, section 11, is amended to read:

Sec. 11. **MORATORIUM ON CONVERSION TRANSACTIONS.**

(a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit health service plan corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may only merge or consolidate with; ~~or~~ convert~~,~~; or transfer, as part of a single transaction or a series of transactions within a 24-month period, all or a ~~substantial portion~~ material amount of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the health maintenance organization. For purposes of this section, "material

amount" means the lesser of ten percent of such an entity's total admitted net assets as of December 31 of the previous year, or $50,000,000.

(b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit health maintenance organization files an intent to dissolve due to insolvency of the corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings are commenced under Minnesota Statutes, chapter 60B.

(c) Nothing in this section shall be construed to authorize a nonprofit health maintenance organization or a nonprofit ~~health~~ service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

(d) This section expires July 1, ~~2019~~ 2023.

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

Sec. 21. **COVERAGE FOR PANDAS OR PANS.**

A health plan's coverage as of January 1, 2019, must be used by the health carrier as the basis for determining whether coverage would not have been provided by the health carrier pursuant to Minnesota Statutes, section 62A.3097, subdivision 4. Treatments and services covered by the health plan as of January 1, 2019, are not eligible for payment as provided under Minnesota Statutes, section 62A.3097, subdivision 4, by the commissioner of commerce.

Sec. 22. **MINNESOTA PREMIUM SECURITY PLAN ADMINISTERED THROUGH THE 2021 BENEFIT YEAR.**

The Minnesota Comprehensive Health Association must administer the Minnesota premium security plan through the 2021 benefit year.

ARTICLE 9
PRESCRIPTION DRUGS

Section 1. Minnesota Statutes 2018, section 62J.23, subdivision 2, is amended to read:

Subd. 2. **Restrictions.** (a) From July 1, 1992, until rules are adopted by the commissioner under this section, the restrictions in the federal Medicare antikickback statutes in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and rules adopted under the federal statutes, apply to all persons in the state, regardless of whether the person participates in any state health care program.

(b) Nothing in paragraph (a) shall be construed to prohibit an individual from receiving a discount or other reduction in price or a limited-time free supply or samples of a prescription drug, medical supply, or medical equipment offered by a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager, so long as:

(1) the discount or reduction in price is provided to the individual in connection with the purchase of a prescription drug, medical supply, or medical equipment prescribed for that individual;

(2) it otherwise complies with the requirements of state and federal law applicable to enrollees of state and federal public health care programs;

(3) the discount or reduction in price does not exceed the amount paid directly by the individual for the prescription drug, medical supply, or medical equipment; and

(4) the limited-time free supply or samples are provided by a physician or pharmacist, as provided by the federal Prescription Drug Marketing Act.

For purposes of this paragraph, "prescription drug" includes prescription drugs that are administered through infusion, and related services and supplies.

(c) No benefit, reward, remuneration, or incentive for continued product use may be provided to an individual or an individual's family by a pharmaceutical manufacturer, medical supply or device manufacturer, or pharmacy benefit manager, except that this prohibition does not apply to:

(1) activities permitted under paragraph (b);

(2) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager providing to a patient, at a discount or reduced price or free of charge, ancillary products necessary for treatment of the medical condition for which the prescription drug, medical supply, or medical equipment was prescribed or provided; and

(3) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager providing to a patient a trinket or memento of insignificant value.

(d) Nothing in this subdivision shall be construed to prohibit a health plan company from offering a tiered formulary with different co-payment or cost-sharing amounts for different drugs.

Sec. 2. **[62Q.528] DRUG COVERAGE IN EMERGENCY SITUATIONS.**

A health plan that provides prescription drug coverage must provide coverage for a prescription drug dispensed by a pharmacist under section 151.211, subdivision 3, under the terms of coverage that would apply had the prescription drug been dispensed according to a prescription.

Sec. 3. Minnesota Statutes 2018, section 151.01, subdivision 23, is amended to read:

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, or licensed advanced practice registered nurse. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f); and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense, and administer under chapter 147A. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A.

Sec. 4. Minnesota Statutes 2018, section 151.06, is amended by adding a subdivision to read:

Subd. 6. **Information provision; sources of lower cost prescription drugs.** (a) The board shall publish a page on its website that provides regularly updated information concerning:

(1) patient assistance programs offered by drug manufacturers, including information on how to access the programs;

(2) the prescription drug assistance program established by the Minnesota Board of Aging under section 256.975, subdivision 9;

(3) the websites through which individuals can access information concerning eligibility for and enrollment in Medicare, medical assistance, MinnesotaCare, and other government-funded programs that help pay for the cost of health care;

(4) availability of providers that are authorized to participate under section 340b of the federal Public Health Services Act, United States Code, title 42, section 256b;

(5) having a discussion with the pharmacist or the consumer's health care provider about alternatives to a prescribed drug, including a lower cost or generic drug if the drug prescribed is too costly for the consumer; and

(6) any other resource that the board deems useful to individuals who are attempting to purchase prescription drugs at lower costs.

(b) The board must prepare educational materials, including brochures and posters, based on the information it provides on its website under paragraph (a). The materials must be in a form that can be downloaded from the board's website and used for patient education by pharmacists and by health care practitioners who are licensed to prescribe. The board is not required to provide printed copies of these materials.

(c) The board shall require pharmacists and pharmacies to make available to patients information on sources of lower cost prescription drugs, including information on the availability of the website established under paragraph (a).

Sec. 5. Minnesota Statutes 2018, section 151.211, subdivision 2, is amended to read:

Subd. 2. **Refill requirements.** Except as provided in subdivision 3, a prescription drug order may be refilled only with the written, electronic, or verbal consent of the prescriber and in accordance with the requirements of this chapter, the rules of the board, and where applicable, section 152.11. The date of such refill must be recorded and initialed upon the original prescription drug order, or within the electronically maintained record of the original prescription drug order, by the pharmacist, pharmacist intern, or practitioner who refills the prescription.

Sec. 6. Minnesota Statutes 2018, section 151.211, is amended by adding a subdivision to read:

Subd. 3. **Emergency prescription refills.** (a) A pharmacist may, using sound professional judgment and in accordance with accepted standards of practice, dispense a legend drug without a current prescription drug order from a licensed practitioner if all of the following conditions are met:

(1) the patient has been compliant with taking the medication and has consistently had the drug filled or refilled as demonstrated by records maintained by the pharmacy;

(2) the pharmacy from which the legend drug is dispensed has record of a prescription drug order for the drug in the name of the patient who is requesting it, but the prescription

drug order does not provide for a refill, or the time during which the refills were valid has elapsed;

(3) the pharmacist has tried but is unable to contact the practitioner who issued the prescription drug order, or another practitioner responsible for the patient's care, to obtain authorization to refill the prescription;

(4) the drug is essential to sustain the life of the patient or to continue therapy for a chronic condition;

(5) failure to dispense the drug to the patient would result in harm to the health of the patient; and

(6) the drug is not a controlled substance listed in section 152.02, subdivisions 3 to 6, except for a controlled substance that has been specifically prescribed to treat a seizure disorder, in which case the pharmacist may dispense up to a 72-hour supply.

(b) If the conditions in paragraph (a) are met, the amount of the drug dispensed by the pharmacist to the patient must not exceed a 30-day supply, or the quantity originally prescribed, whichever is less, except as provided for controlled substances in paragraph (a), clause (6). If the standard unit of dispensing for the drug exceeds a 30-day supply, the amount of the drug dispensed or sold must not exceed the standard unit of dispensing.

(c) A pharmacist shall not dispense or sell the same drug to the same patient, as provided in this section, more than one time in any 12-month period.

(d) A pharmacist must notify the practitioner who issued the prescription drug order not later than 72 hours after the drug is sold or dispensed. The pharmacist must request and receive authorization before any additional refills may be dispensed. If the practitioner declines to provide authorization for additional refills, the pharmacist must inform the patient of that fact.

(e) The record of a drug sold or dispensed under this section shall be maintained in the same manner required for prescription drug orders under this section.

Sec. 7. **[151.555] PRESCRIPTION DRUG REPOSITORY PROGRAM.**

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

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility registered under chapter 144D where there is centralized storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47;

(6) a drug manufacturer licensed under section 151.252; or

(7) an individual at least 18 years of age, provided that the drug or medical supply that is donated was obtained legally and meets the requirements of this section for donation.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription and nonprescription medical supply needed to administer a prescription drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

Subd. 2. **Establishment.** By January 1, 2020, the Board of Pharmacy shall establish a drug repository program, through which donors may donate a drug or medical supply for use by an individual who meets the eligibility criteria specified under subdivision 5. The board shall contract with a central repository that meets the requirements of subdivision 3 to implement and administer the prescription drug repository program.

Subd. 3. **Central repository requirements.** (a) The board shall publish a request for proposal for participants who meet the requirements of this subdivision and are interested in acting as the central repository for the drug repository program. The board shall follow all applicable state procurement procedures in the selection process.

(b) To be eligible to act as the central repository, the participant must be a wholesale drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance with all applicable federal and state statutes, rules, and regulations.

(c) The central repository shall be subject to inspection by the board pursuant to section 151.06, subdivision 1.

(d) The central repository shall comply with all applicable federal and state laws, rules, and regulations pertaining to the drug repository program, drug storage, and dispensing. The facility must maintain in good standing any state license or registration that applies to the facility.

Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the drug repository program, a health care facility must agree to comply with all applicable federal and state laws, rules, and regulations pertaining to the drug repository program, drug storage, and dispensing. The facility must also agree to maintain in good standing any required state license or registration that may apply to the facility.

(b) A local repository may elect to participate in the program by submitting the following information to the central repository on a form developed by the board and made available on the board's website:

(1) the name, street address, and telephone number of the health care facility and any state-issued license or registration number issued to the facility, including the issuing state agency;

(2) the name and telephone number of a responsible pharmacist or practitioner who is employed by or under contract with the health care facility; and

(3) a statement signed and dated by the responsible pharmacist or practitioner indicating that the health care facility meets the eligibility requirements under this section and agrees to comply with this section.

(c) Participation in the drug repository program is voluntary. A local repository may withdraw from participation in the drug repository program at any time by providing written notice to the central repository on a form developed by the board and made available on the board's website. The central repository shall provide the board with a copy of the withdrawal notice within ten business days from the date of receipt of the withdrawal notice.

Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for the drug repository program, an individual must submit to a local repository an intake application form that is signed by the individual and attests that the individual:

(1) is a resident of Minnesota;

(2) is uninsured and is not enrolled in the medical assistance program under chapter 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage, or is underinsured;

(3) acknowledges that the drugs or medical supplies to be received through the program may have been donated; and

(4) consents to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

(b) Upon determining that an individual is eligible for the program, the local repository shall furnish the individual with an identification card. The card shall be valid for one year from the date of issuance and may be used at any local repository. A new identification card may be issued upon expiration once the individual submits a new application form.

(c) The local repository shall send a copy of the intake application form to the central repository by regular mail, facsimile, or secured e-mail within ten days from the date the application is approved by the local repository.

(d) The board shall develop and make available on the board's website an application form and the format for the identification card.

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a) A donor may donate prescription drugs or medical supplies to the central repository or a local repository if the drug or supply meets the requirements of this section as determined by a pharmacist or practitioner who is employed by or under contract with the central repository or a local repository.

(b) A prescription drug is eligible for donation under the drug repository program if the following requirements are met:

(1) the donation is accompanied by a drug repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d);

(2) the drug's expiration date is at least six months after the date the drug was donated. If a donated drug bears an expiration date that is less than six months from the donation date, the drug may be accepted and distributed if the drug is in high demand and can be dispensed for use by a patient before the drug's expiration date;

(3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging is unopened;

(4) the drug or the packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;

(5) the drug does not require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located in Minnesota; and

(6) the prescription drug is not a controlled substance.

(c) A medical supply is eligible for donation under the drug repository program if the following requirements are met:

(1) the supply has no physical signs of tampering, misbranding, or alteration and there is no reason to believe it has been adulterated, tampered with, or misbranded;

(2) the supply is in its original, unopened, sealed packaging;

(3) the donation is accompanied by a drug repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d); and

(4) if the supply bears an expiration date, the date is at least six months later than the date the supply was donated. If the donated supply bears an expiration date that is less than six months from the date the supply was donated, the supply may be accepted and distributed if the supply is in high demand and can be dispensed for use by a patient before the supply's expiration date.

(d) The board shall develop the drug repository donor form and make it available on the board's website. The form must state that to the best of the donor's knowledge the donated drug or supply has been properly stored under appropriate temperature and humidity conditions, and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

(e) Donated drugs and supplies may be shipped or delivered to the premises of the central repository or a local repository, and shall be inspected by a pharmacist or an authorized practitioner who is employed by or under contract with the repository and who has been designated by the repository to accept donations. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall inventory all drugs and supplies donated to the repository. For each drug, the inventory must include the drug's name, strength, quantity, manufacturer, expiration date, and the date the drug was donated. For each medical supply, the inventory must include a description of the supply, its manufacturer, the date the supply was donated, and, if applicable, the supply's brand name and expiration date.

Subd. 7. **Standards and procedures for inspecting and storing donated prescription drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated prescription drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory. If donated drugs or supplies are not inspected immediately upon receipt, a repository must quarantine the donated drugs or supplies separately from all dispensing stock until the donated drugs or supplies have been inspected and (1) approved for dispensing under the program; (2) disposed of pursuant to paragraph (c); or (3) returned to the donor pursuant to paragraph (d).

(c) The central repository and local repositories shall dispose of all prescription drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or prescription drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies

to eligible individuals in the following priority order: (1) individuals who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured. A repository shall dispense donated prescription drugs in compliance with applicable federal and state laws and regulations for dispensing prescription drugs, including all requirements relating to packaging, labeling, record keeping, drug utilization review, and patient counseling.

(b) Before dispensing or administering a drug or supply, the pharmacist or practitioner shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

(c) Before a drug or supply is dispensed or administered to an individual, the individual must sign a drug repository recipient form acknowledging that the individual understands the information stated on the form. The board shall develop the form and make it available on the board's website. The form must include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug or supply has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the central repository or local repository, the Board of Pharmacy, and any other participant of the drug repository program cannot guarantee the safety of the drug or medical supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or medical supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each drug or medical supply dispensed or administered by that repository.

(b) A repository that dispenses or administers a drug or medical supply through the drug repository program shall not receive reimbursement under the medical assistance program or the MinnesotaCare program for that dispensed or administered drug or supply.

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the drug repository program to other participating repositories for use pursuant to this program.

(b) A local repository that elects not to dispense donated drugs or supplies must transfer all donated drugs and supplies to the central repository. A copy of the donor form that was completed by the original donor under subdivision 6 must be provided to the central repository at the time of transfer.

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's website:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) drug repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) drug repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated prescription drugs and medical supplies must be maintained by a repository for a minimum of five years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the drug repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A health care facility participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a drug or medical supply is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug or supply is dispensed and no disciplinary action by a health-related licensing board shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the drug or medical supply.

Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care facility to donate a drug to a central or local repository when federal or state law requires the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can credit the payer for the amount of the drug returned.

Sec. 8. **[214.122] INFORMATION PROVISION; PHARMACEUTICAL ASSISTANCE PROGRAMS.**

(a) The Board of Medical Practice and the Board of Nursing shall at least annually inform licensees who are authorized to prescribe prescription drugs of the availability of the Board of Pharmacy's website that contains information on resources and programs to assist patients with the cost of prescription drugs. The boards shall provide licensees with the website address established by the Board of Pharmacy under section 151.06, subdivision 6, and the materials described under section 151.06, subdivision 6, paragraph (b).

(b) Licensees must make available to patients information on sources of lower cost prescription drugs, including information on the availability of the website established by the Board of Pharmacy under section 151.06, subdivision 6.

ARTICLE 10
HEALTH-RELATED LICENSING BOARDS

Section 1. **[144A.291] FEES.**

Subdivision 1. **Nonrefundable fees.** All fees are nonrefundable.

Subd. 2. **Amounts.** (a) Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board as required to sustain board operations. The maximum amounts of fees are:

(1) application for licensure, $200;

(2) for a prospective applicant for a review of education and experience advisory to the license application, $100, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;

(3) state examination, $125;

(4) initial license, $250 if issued between July 1 and December 31, $100 if issued between January 1 and June 30;

(5) acting administrator permit, $400;

(6) renewal license, $250;

(7) duplicate license, $50;

(8) reinstatement fee, $250;

(9) health services executive initial license, $200;

(10) health services executive renewal license, $200;

(11) reciprocity verification fee, $50;

(12) second shared administrator assignment, $250;

(13) continuing education fees:

(i) greater than 6 hours, $50; and

(ii) 7 hours or more, $75;

(14) education review, $100;

(15) fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:

(i) for less than seven clock hours, $30; and

(ii) for seven or more clock hours, $50;

(16) fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:

(i) for less than seven clock hours total, $30; and

(ii) for seven or more clock hours total, $50;

(17) late renewal fee, $75;

(18) fee to a licensee for verification of licensure status and examination scores, $30;

(19) registration as a registered continuing education sponsor, $1,000; and

(20) mail labels, $75.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 2. Minnesota Statutes 2018, section 147.037, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** The board shall issue a license to practice medicine to any person who satisfies the requirements in paragraphs (a) to (g).

(a) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (e), (f), (g), and (h).

(b) The applicant shall present evidence satisfactory to the board that the applicant is a graduate of a medical or osteopathic school approved by the board as equivalent to accredited United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation, or other relevant data. If the applicant is a graduate of a medical or osteopathic program that is not accredited by the Liaison Committee for Medical Education or the American Osteopathic Association, the applicant may use the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS) or its successor. If the applicant uses this service as allowed under this paragraph, the physician application fee may be less than $200 but must not exceed the cost of administering this paragraph.

(c) The applicant shall present evidence satisfactory to the board that the applicant has been awarded a certificate by the Educational Council for Foreign Medical Graduates, and the applicant has a working ability in the English language sufficient to communicate with patients and physicians and to engage in the practice of medicine.

(d) The applicant shall present evidence satisfactory to the board of the completion of ~~two years~~ one year of graduate, clinical medical training in a program ~~located in the United States, its territories, or Canada and accredited by a national accrediting organization approved by the board~~ accredited by a national accrediting organization approved by the board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization. This requirement does not apply:

(1) to an applicant who is admitted as a permanent immigrant to the United States on or before October 1, 1991, as a person of exceptional ability in the sciences according to Code of Federal Regulations, title 20, section 656.22(d); or

(2) to an applicant holding a valid license to practice medicine in another country and issued a permanent immigrant visa after October 1, 1991, as a person of extraordinary ability in the field of science or as an outstanding professor or researcher according to Code of Federal Regulations, title 8, section 204.5(h) and (i), or a temporary nonimmigrant visa as a person of extraordinary ability in the field of science according to Code of Federal Regulations, title 8, section 214.2(o),

provided that a person under clause (1) or (2) is admitted pursuant to rules of the United States Department of Labor~~; or~~

~~(3) to an applicant who is licensed in another state, has practiced five years without disciplinary action in the United States, its territories, or Canada, has completed one year of the graduate, clinical medical training required by this paragraph, and has passed the Special Purpose Examination of the Federation of State Medical Boards within three attempts in the 24 months before licensing~~.

(e) The applicant must:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the United States Medical Licensing Examination program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2), or the Medical Council of Canada; and

(2) ~~have a current license from the equivalent licensing agency in another state or country and,~~ if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, of the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and three of the USMLE within the required three attempts, the applicant may be granted a license provided the applicant:

(i) has passed each of steps one, two, and three with passing scores as recommended by the USMLE program within no more than four attempts for any of the three steps;

(ii) is currently licensed in another state; and

(iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

(f) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(g) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (f). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

Sec. 3. Minnesota Statutes 2018, section 147.0375, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** The board shall issue a license to practice medicine to any person who satisfies the requirements in paragraphs (a) to (d).

(a) The applicant must satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (e), (f), (g), and (h).

(b) The applicant must present evidence satisfactory to the board that the applicant is a graduate of a medical or osteopathic school approved by the board as equivalent to accredited United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation, or other relevant data. If the applicant is a graduate of a medical or osteopathic program that is not accredited by the Liaison Committee for Medical Education or the American Osteopathic Association, the applicant may use the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS) or its successor. If the applicant uses this service as allowed under this paragraph, the physician application fee may be less than $200 but must not exceed the cost of administering this paragraph.

(c) The applicant must present evidence satisfactory to the board of the completion of ~~two years~~ one year of graduate, clinical medical training in a program ~~located in the United States, its territories, or Canada and accredited by a national accrediting organization approved by the board~~ accredited by a national accrediting organization approved by the

board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization. This requirement does not apply:

(1) to an applicant who is admitted as a permanent immigrant to the United States on or before October 1, 1991, as a person of exceptional ability in the sciences according to Code of Federal Regulations, title 20, section 656.22 (d); or

(2) to an applicant holding a valid license to practice medicine in another state or country and issued a permanent immigrant visa after October 1, 1991, as a person of extraordinary ability in the field of science or as an outstanding professor or researcher according to Code of Federal Regulations, title 8, section 204.5(h) and (i), or a temporary nonimmigrant visa or status as a person of extraordinary ability in the field of science according to Code of Federal Regulations, title 8, section 214.2(o)~~; or~~

~~(3) to an applicant who is licensed in another state, has practiced five years without disciplinary action in the United States, its territories, or Canada, has completed one year of the graduate, clinical medical training required by this paragraph, and has passed the Special Purpose Examination of the Federation of State Medical Boards within three attempts in the 24 months before licensing~~.

(d) The applicant must present evidence satisfactory to the board that the applicant has been appointed to serve as a faculty member of a medical school accredited by the Liaison Committee of Medical Education or an osteopathic medical school accredited by the American Osteopathic Association.

Sec. 4. Minnesota Statutes 2018, section 147D.27, is amended by adding a subdivision to read:

Subd. 6. **Additional fees.** (a) The following fees also apply:

(1) traditional midwifery annual registration fee, $100;

(2) traditional midwifery application fee, $100;

(3) traditional midwifery late fee, $75;

(4) traditional midwifery inactive status, $50;

(5) traditional midwifery temporary permit, $75;

(6) traditional midwifery certification fee, $25;

(7) duplicate license or registration fee, $20;

(8) certification letter, $25;

(9) education or training program approval fee, $100; and

(10) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

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

Sec. 5. Minnesota Statutes 2018, section 147E.40, subdivision 1, as amended by Laws 2019, chapter 8, article 7, section 8, is amended to read:

Subdivision 1. **Fees.** (a) Fees are as follows:

(1) registration application fee, $200;

(2) renewal fee, $150;

(3) late fee, $75;

(4) inactive status fee, $50;

(5) temporary permit fee, $25;

(6) naturopathic doctor certification fee, $25;

(7) naturopathic doctor duplicate license fee, $20;

~~(6)~~ (8) naturopathic doctor emeritus registration fee, $50;

(9) naturopathic doctor certification fee, $25;

~~(7)~~ (10) duplicate license or registration fee, $20;

~~(8)~~ (11) certification letter fee, $25;

~~(9)~~ (12) verification fee, $25;

~~(10)~~ (13) education or training program approval fee, $100; and

~~(11)~~ (14) report creation and generation fee, $60 per hour billed in quarter-hour increments with a quarter-hour minimum.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

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

Sec. 6. Minnesota Statutes 2018, section 147F.17, subdivision 1, as amended by Laws 2019, chapter 8, article 7, section 9, is amended to read:

Subdivision 1. **Fees.** (a) Fees are as follows:

(1) license application fee, $200;

(2) initial licensure and annual renewal, $150;

(3) late fee, $75;

(4) genetic counselor certification fee, $25;

~~(4)~~ (5) temporary license fee, $60;

~~(5)~~ (6) duplicate license fee, $20;

~~(6)~~ (7) certification letter fee, $25;

~~(7)~~ (8) education or training program approval fee, $100;

~~(8)~~ (9) report creation and generation fee, $60 per hour billed in quarter-hour increments with a quarter-hour minimum; and

~~(9)~~ (10) criminal background check fee, $32.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

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

Sec. 7. Minnesota Statutes 2018, section 148.59, is amended to read:

148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, ~~$135~~ $200;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; ~~and~~

(9) license verification, $50~~.~~;

(10) state jurisprudence examination, $75;

(11) optometric education continuing education data bank registration, $25; and

(12) miscellaneous labels and data retrieval, $50.

Sec. 8. Minnesota Statutes 2018, section 148.6445, subdivision 1, is amended to read:

Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists is ~~$145~~ $185. The initial licensure fee for occupational therapy assistants is ~~$80~~ $105. ~~The board shall prorate fees based on the number of quarters remaining in the biennial licensure period.~~

Sec. 9. Minnesota Statutes 2018, section 148.6445, subdivision 2, is amended to read:

Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for occupational therapists is ~~$145~~ $185. The biennial licensure renewal fee for occupational therapy assistants is ~~$80~~ $105.

Sec. 10. Minnesota Statutes 2018, section 148.6445, subdivision 2a, is amended to read:

Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is ~~$25~~ $30.

Sec. 11. Minnesota Statutes 2018, section 148.6445, subdivision 3, is amended to read:

Subd. 3. **Late fee.** The fee for late submission of a renewal application is ~~$25~~ $50.

Sec. 12. Minnesota Statutes 2018, section 148.6445, subdivision 4, is amended to read:

Subd. 4. **Temporary licensure fee.** The fee for temporary licensure is ~~$50~~ $75.

Sec. 13. Minnesota Statutes 2018, section 148.6445, subdivision 5, is amended to read:

Subd. 5. **Limited licensure fee.** The fee for limited licensure is ~~$96~~ $100.

Sec. 14. Minnesota Statutes 2018, section 148.6445, subdivision 6, is amended to read:

Subd. 6. **Fee for course approval after lapse of licensure.** The fee for course approval after lapse of licensure is ~~$96~~ $100.

Sec. 15. Minnesota Statutes 2018, section 148.6445, subdivision 10, is amended to read:

Subd. 10. **Use of fees.** (a) All fees are nonrefundable. The board shall only use fees collected under this section for the purposes of administering this chapter. The legislature must not transfer money generated by these fees from the state government special revenue fund to the general fund.

(b) Licensure fees are for the exclusive use of the board and shall be established by the board not to exceed the nonrefundable amounts in this section.

Sec. 16. Minnesota Statutes 2018, section 148.7815, subdivision 1, as amended by Laws 2019, chapter 8, article 7, section 10, is amended to read:

Subdivision 1. **Fees.** (a) The board shall establish fees as follows:

(1) application fee, $50;

(2) annual license fee, $100;

(3) athletic trainer certification fee, $25;

(4) athletic trainer duplicate license fee, $20;

~~(3)~~ (5) late fee, $15;

~~(4)~~ (6) duplicate license or registration fee, $20;

~~(5)~~ (7) certification letter fee, $25;

~~(6)~~ (8) verification fee, $25;

~~(7)~~ (9) education or training program approval fee, $100; ~~and~~

~~(8)~~ (10) report creation and generation fee, $60 per hour~~.~~ billed in quarter-hour increments with a quarter-hour minimum; and

(11) examination administrative fee:

(i) half day, $50; and

(ii) full day, $80.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

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

Sec. 17. **[148.981] FEES.**

Subdivision 1. **Licensing fees.** The nonrefundable fees for licensure shall be established by the board, not to exceed the following amounts:

(1) application for admission to national standardized examination, $150;

(2) application for professional responsibility examination, $150;

(3) application for licensure as a licensed psychologist, $500;

(4) renewal of license for a licensed psychologist, $500;

(5) late renewal of license for a licensed psychologist, $250;

(6) application for converting from master's to doctoral level licensure, $150;

(7) application for guest licensure, $150;

(8) certificate replacement fee, $25;

(9) mailing and duplication fee, $5;

(10) statute and rule book fee, $10;

(11) verification fee, $20; and

(12) fee for optional preapproval of postdoctoral supervision, $50.

Subd. 2. **Continuing education sponsor fee.** A sponsor applying for approval of a continuing education activity pursuant to Minnesota Rules, part 7200.3830, subpart 2, shall submit with the application a fee to be established by the board, not to exceed $80 for each activity.

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

Sec. 18. Minnesota Statutes 2018, section 148E.180, is amended to read:

148E.180 FEE AMOUNTS.

Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$45~~ $75;

(2) for a licensed graduate social worker, ~~$45~~ $75;

(3) for a licensed independent social worker, ~~$45~~ $75;

(4) for a licensed independent clinical social worker, ~~$45~~ $75;

(5) for a temporary license, $50; and

(6) for a ~~licensure~~ license by endorsement, ~~$85~~ $115.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305;

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335;

(5) for an emeritus inactive license, ~~$43.20~~ $65;

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Subd. 3. **Renewal fees.** Nonrefundable renewal fees for licensure ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305; and

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335.

Subd. 4. **Continuing education provider fees.** Continuing education provider fees are ~~as follows~~ the following nonrefundable amounts:

(1) for a provider who offers programs totaling one to eight clock hours in a one-year period according to section 148E.145, $50;

(2) for a provider who offers programs totaling nine to 16 clock hours in a one-year period according to section 148E.145, $100;

(3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period according to section 148E.145, $200;

(4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period according to section 148E.145, $400; and

(5) for a provider who offers programs totaling 49 or more clock hours in a one-year period according to section 148E.145, $600.

Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

(2) supervision plan late fee, $40; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Subd. 6. **License cards and wall certificates.** (a) The nonrefundable fee for a license card as specified in section 148E.095 is $10.

(b) The nonrefundable fee for a license wall certificate as specified in section 148E.095 is $30.

Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable amounts:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision 3.

Sec. 19. Minnesota Statutes 2018, section 150A.06, subdivision 3, is amended to read:

Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists, dental therapists, dental hygienists, or dental assistants, except that pertaining to the law of Minnesota relating to dentistry and the rules of the board, may, at the discretion of the board, be waived for an applicant who presents a certificate of having passed all components of

the National Board Dental Examinations or evidence of having maintained an adequate scholastic standing as determined by the board.

(b) The board shall waive the clinical examination required for licensure for any dentist applicant who is a graduate of a dental school accredited by the Commission on Dental Accreditation, who has passed all components of the National Board Dental Examinations, and who has satisfactorily completed a ~~Minnesota-based~~ postdoctoral general dentistry residency program (GPR) or an advanced education in general dentistry (AEGD) program after January 1, 2004. The postdoctoral program must be accredited by the Commission on Dental Accreditation, be of at least one year's duration, and include an outcome assessment evaluation assessing the resident's competence to practice dentistry. The board may require the applicant to submit any information deemed necessary by the board to determine whether the waiver is applicable.

Sec. 20. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to read:

Subd. 10. **Emeritus inactive license.** A person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting pursuant to section 150A.05 or Minnesota Rules, part 3100.8500, who retires from active practice in the state may apply to the board for emeritus inactive licensure. An application for emeritus inactive licensure may be made on the biennial licensing form or by petitioning the board, and the applicant must pay a onetime application fee pursuant to section 150A.091, subdivision 19. In order to receive emeritus inactive licensure, the applicant must be in compliance with board requirements and cannot be the subject of current disciplinary action resulting in suspension, revocation, disqualification, condition, or restriction of the licensee to practice dentistry, dental therapy, dental hygiene, or dental assisting. An emeritus inactive license is not a license to practice, but is a formal recognition of completion of a person's dental career in good standing.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to read:

Subd. 11. **Emeritus active licensure.** (a) A person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting may apply for an emeritus active license if the person is retired from active practice, is in compliance with board requirements, and is not the subject of current disciplinary action resulting in suspension, revocation, disqualification,

condition, or restriction of the license to practice dentistry, dental therapy, dental hygiene, or dental assisting.

(b) An emeritus active licensee may engage only in the following types of practice:

(1) pro bono or volunteer dental practice;

(2) paid practice not to exceed 500 hours per calendar year for the exclusive purpose of providing licensing supervision to meet the board's requirements; or

(3) paid consulting services not to exceed 500 hours per calendar year.

(c) An emeritus active licensee shall not hold out as a full licensee and may only hold out as authorized to practice as described in this subdivision. The board may take disciplinary or corrective action against an emeritus active licensee based on violations of applicable law or board requirements.

(d) A person may apply for an emeritus active license by completing an application form specified by the board and must pay the application fee pursuant to section 150A.091, subdivision 20.

(e) If an emeritus active license is not renewed every two years, the license expires. The renewal date is the same as the licensee's renewal date when the licensee was in active practice. In order to renew an emeritus active license, the licensee must:

(1) complete an application form as specified by the board;

(2) pay the required renewal fee pursuant to section 150A.091, subdivision 20; and

(3) report at least 25 continuing education hours completed since the last renewal, which must include:

(i) at least one hour in two different required CORE areas;

(ii) at least one hour of mandatory infection control;

(iii) for dentists and dental therapists, at least 15 hours of fundamental credits for dentists and dental therapists, and for dental hygienists and dental assistants, at least seven hours of fundamental credits; and

(iv) for dentists and dental therapists, no more than ten elective credits, and for dental hygienists and dental assistants, no more than six elective credits.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 22. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision to read:

Subd. 19. **Emeritus inactive license.** An individual applying for emeritus inactive licensure under section 150A.06, subdivision 10, must pay a onetime fee of $50. There is no renewal fee for an emeritus inactive license.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 23. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision to read:

Subd. 20. **Emeritus active license.** An individual applying for emeritus active licensure under section 150A.06, subdivision 11, must pay a fee upon application and upon renewal every two years. The fees for emeritus active license application and renewal are as follows: dentist, $212; dental therapist, $100; dental hygienist, $75; and dental assistant, $55.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 24. Minnesota Statutes 2018, section 151.01, subdivision 31, is amended to read:

Subd. 31. **Central service pharmacy.** "Central service pharmacy" means a pharmacy that ~~may provide~~ performs those activities involved in the dispensing ~~functions,~~ of a drug ~~utilization review, packaging, labeling, or delivery of a prescription product to~~ for another pharmacy ~~for the purpose of filling a prescription~~, pursuant to the requirements of this chapter and the rules of the board.

Sec. 25. Minnesota Statutes 2018, section 151.01, subdivision 35, is amended to read:

Subd. 35. **Compounding.** "Compounding" means preparing, mixing, assembling, packaging, and labeling a drug for an identified individual patient as a result of a practitioner's prescription drug order. Compounding also includes anticipatory compounding, as defined in this section, and the preparation of drugs in which all bulk drug substances and components are nonprescription substances. Compounding does not include mixing or reconstituting a drug according to the product's labeling or to the manufacturer's directions, provided that such labeling has been approved by the United States Food and Drug Administration (FDA) or the manufacturer is licensed under section 151.252. Compounding does not include the preparation of a drug for the purpose of, or incident to, research, teaching, or chemical analysis, provided that the drug is not prepared for dispensing or administration to patients. All compounding, regardless of the type of product, must be done pursuant to a prescription drug order unless otherwise permitted in this chapter or by the rules of the board.

Compounding does not include a minor deviation from such directions with regard to radioactivity, volume, or stability, which is made by or under the supervision of a licensed nuclear pharmacist or a physician, and which is necessary in order to accommodate circumstances not contemplated in the manufacturer's instructions, such as the rate of radioactive decay or geographical distance from the patient.

Sec. 26. Minnesota Statutes 2018, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, ~~$145~~ $175;

(2) pharmacist licensed by reciprocity, ~~$240~~ $275;

(3) pharmacy intern, ~~$37.50~~ $50;

(4) pharmacy technician, ~~$37.50~~ $50;

(5) pharmacy, ~~$225~~ $260;

(6) drug wholesaler, legend drugs only, ~~$235~~ $260;

(7) drug wholesaler, legend and nonlegend drugs, ~~$235~~ $260;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$210~~ $260;

(9) drug wholesaler, medical gases, ~~$175~~ $260;

(10) ~~drug wholesaler, also licensed as a pharmacy in Minnesota, $150~~ third-party logistics provider, $260;

(11) drug manufacturer, legend drugs only, ~~$235~~ $260;

(12) drug manufacturer, legend and nonlegend drugs, ~~$235~~ $260;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$210~~ $260;

(14) drug manufacturer, medical gases, ~~$185~~ $260;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$150~~ $260;

(16) medical gas distributor, ~~$110~~ $260;

(17) controlled substance researcher, $75; and

(18) pharmacy professional corporation, ~~$125~~ $150.

Sec. 27. Minnesota Statutes 2018, section 151.065, subdivision 2, is amended to read:

Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~$145~~ $175.

Sec. 28. Minnesota Statutes 2018, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, ~~$145~~ $175;

(2) pharmacy technician, ~~$37.50~~ $50;

(3) pharmacy, ~~$225~~ $260;

(4) drug wholesaler, legend drugs only, ~~$235~~ $260;

(5) drug wholesaler, legend and nonlegend drugs, ~~$235~~ $260;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$210~~ $260;

(7) drug wholesaler, medical gases, ~~$185~~ $260;

(8) ~~drug wholesaler, also licensed as a pharmacy in Minnesota, $150~~ third-party logistics provider, $260;

(9) drug manufacturer, legend drugs only, ~~$235~~ $260;

(10) drug manufacturer, legend and nonlegend drugs, ~~$235~~ $260;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~$210~~ $260;

(12) drug manufacturer, medical gases, ~~$185~~ $260;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$150~~ $260;

(14) medical gas distributor, ~~$110~~ $260;

(15) controlled substance researcher, $75; and

(16) pharmacy professional corporation, ~~$75~~ $100.

Sec. 29. Minnesota Statutes 2018, section 151.065, subdivision 6, is amended to read:

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $90.

(c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics provider, or a medical gas distributor who has allowed the license of the establishment to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

(d) A controlled substance researcher who has allowed the researcher's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

(e) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

Sec. 30. Minnesota Statutes 2018, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used

in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or

violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, ~~drunkenness,~~ use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, ~~drunkenness,~~ use of alcohol, drugs, narcotics,

chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas distributor, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(16) for a pharmacist or pharmacy, improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(17) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients; ~~and~~

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521; and

(iii) any arrangement through which a pharmacy, in which the prescribing practitioner does not have a significant ownership interest, fills a prescription drug order and the prescribing practitioner is involved in any manner, directly or indirectly, in setting the price for the filled prescription that is charged to the patient, the patient's insurer or pharmacy benefit manager, or other person paying for the prescription or, in the case of veterinary patients, the price for the filled prescription that is charged to the client or other person paying for the prescription, except that a veterinarian and a pharmacy may enter into such an arrangement provided that the client or other person paying for the prescription is notified, in writing and with each prescription dispensed, about the arrangement, unless such arrangement involves pharmacy services provided for livestock, poultry, and agricultural production systems, in which case client notification would not be required;

(18) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws or rules;

(19) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

(21) knowingly providing false or misleading information that is directly related to the care of a patient unless done for an accepted therapeutic purpose such as the dispensing and administration of a placebo;

(22) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; and

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professionals services program for reasons other than the satisfactory completion of the program.

Sec. 31. Minnesota Statutes 2018, section 151.15, subdivision 1, is amended to read:

Subdivision 1. **Location.** It shall be unlawful for any person to compound~~,~~ or dispense~~, vend, or sell~~ drugs~~, medicines, chemicals, or poisons~~ in any place other than a pharmacy, except as provided in this chapter; except that a licensed pharmacist or pharmacist intern working within a licensed hospital may receive a prescription drug order and access the hospital's pharmacy prescription processing system through secure and encrypted electronic means in order to process the prescription drug order.

Sec. 32. Minnesota Statutes 2018, section 151.15, is amended by adding a subdivision to read:

Subd. 5. **Receipt of emergency prescription orders.** A pharmacist, when that pharmacist is not present within a licensed pharmacy, may accept a written, verbal, or electronic prescription drug order from a practitioner only if:

(1) the prescription drug order is for an emergency situation where waiting for the pharmacist to travel to a licensed pharmacy to accept the prescription drug order would likely cause the patient to experience significant physical harm or discomfort;

(2) the pharmacy from which the prescription drug order will be dispensed is closed for business;

(3) the pharmacist has been designated to be on call for the licensed pharmacy that will fill the prescription drug order;

(4) electronic prescription drug orders are received through secure and encrypted electronic means;

(5) the pharmacist takes reasonable precautions to ensure that the prescription drug order will be handled in a manner consistent with federal and state statutes regarding the handling of protected health information; and

(6) the pharmacy from which the prescription drug order will be dispensed has relevant and appropriate policies and procedures in place and makes them available to the board upon request.

Sec. 33. Minnesota Statutes 2018, section 151.15, is amended by adding a subdivision to read:

Subd. 6. **Processing of emergency prescription orders.** A pharmacist, when that pharmacist is not present within a licensed pharmacy, may access a pharmacy prescription processing system through secure and encrypted electronic means in order to process an emergency prescription accepted pursuant to subdivision 5 only if:

(1) the pharmacy from which the prescription drug order will be dispensed is closed for business;

(2) the pharmacist has been designated to be on call for the licensed pharmacy that will fill the prescription drug order;

(3) the prescription drug order is for a patient of a long-term care facility or a county correctional facility;

(4) the prescription drug order is not being processed pursuant to section 151.58;

(5) the prescription drug order is processed pursuant to this chapter and the rules promulgated thereunder; and

(6) the pharmacy from which the prescription drug order will be dispensed has relevant and appropriate policies and procedures in place and makes them available to the board upon request.

Sec. 34. Minnesota Statutes 2018, section 151.19, subdivision 1, is amended to read:

Subdivision 1. **Pharmacy licensure requirements.** (a) No person shall operate a pharmacy without first obtaining a license from the board and paying any applicable fee specified in section 151.065. The license shall be displayed in a conspicuous place in the pharmacy for which it is issued and expires on June 30 following the date of issue. It is unlawful for any person to operate a pharmacy unless the license has been issued to the person by the board.

(b) Application for a pharmacy license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a pharmacy located within the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal and state law and according to rules adopted by the board. No license shall be issued for a pharmacy located outside of the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal law and, when dispensing medications for residents of this state, the laws of this state, and Minnesota Rules.

(d) No license shall be issued or renewed for a pharmacy that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of such licensure or registration.

(e) The board shall require a separate license for each pharmacy located within the state and for each pharmacy located outside of the state at which any portion of the dispensing process occurs for drugs dispensed to residents of this state.

(f) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed license for a pharmacy ~~unless~~, the board may require the pharmacy ~~passes~~ to pass an inspection conducted by an authorized representative of the board. In the case of a pharmacy located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of

an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(g) The board shall not issue an initial or renewed license for a pharmacy located outside of the state unless the applicant discloses and certifies:

(1) the location, names, and titles of all principal corporate officers and all pharmacists who are involved in dispensing drugs to residents of this state;

(2) that it maintains its records of drugs dispensed to residents of this state so that the records are readily retrievable from the records of other drugs dispensed;

(3) that it agrees to cooperate with, and provide information to, the board concerning matters related to dispensing drugs to residents of this state;

(4) that, during its regular hours of operation, but no less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to the patients' records; the toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this state; and

(5) that, upon request of a resident of a long-term care facility located in this state, the resident's authorized representative, or a contract pharmacy or licensed health care facility acting on behalf of the resident, the pharmacy will dispense medications prescribed for the resident in unit-dose packaging or, alternatively, comply with section 151.415, subdivision 5.

(h) This subdivision does not apply to a manufacturer licensed under section 151.252, subdivision 1, a wholesale drug distributor licensed under section 151.47, or a third-party logistics provider, to the extent the manufacturer, wholesale drug distributor, or third-party logistics provider is engaged in the distribution of dialysate or devices necessary to perform home peritoneal dialysis on patients with end-stage renal disease, if:

(1) the manufacturer or its agent leases or owns the licensed manufacturing or wholesaling facility from which the dialysate or devices will be delivered;

(2) the dialysate is comprised of dextrose or icodextrin and has been approved by the United States Food and Drug Administration;

(3) the dialysate is stored and delivered in its original, sealed, and unopened manufacturer's packaging;

(4) the dialysate or devices are delivered only upon:

(i) receipt of a physician's order by a Minnesota licensed pharmacy; and

(ii) the review and processing of the prescription by a pharmacist licensed by the state in which the pharmacy is located, who is employed by or under contract to the pharmacy;

(5) prescriptions, policies, procedures, and records of delivery are maintained by the manufacturer for a minimum of three years and are made available to the board upon request; and

(6) the manufacturer or the manufacturer's agent delivers the dialysate or devices directly to:

(i) a patient with end-stage renal disease for whom the prescription was written or the patient's designee, for the patient's self-administration of the dialysis therapy; or

(ii) a health care provider or institution, for administration or delivery of the dialysis therapy to a patient with end-stage renal disease for whom the prescription was written.

Sec. 35. Minnesota Statutes 2018, section 151.19, subdivision 3, is amended to read:

Subd. 3. **Sale of federally restricted medical gases.** (a) A person or establishment not licensed as a pharmacy or a practitioner shall not engage in the retail sale or distribution of federally restricted medical gases without first obtaining a registration from the board and paying the applicable fee specified in section 151.065. The registration shall be displayed in a conspicuous place in the business for which it is issued and expires on the date set by the board. It is unlawful for a person to sell or distribute federally restricted medical gases unless a certificate has been issued to that person by the board.

(b) Application for a medical gas distributor registration under this section shall be made in a manner specified by the board.

(c) No registration shall be issued or renewed for a medical gas distributor located within the state unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board. No license shall be issued for a medical gas distributor located outside of the state unless the applicant agrees to operate in a manner prescribed by federal law and, when distributing medical gases for residents of this state, the laws of this state and Minnesota Rules.

(d) No registration shall be issued or renewed for a medical gas distributor that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of the licensure or registration. The board may, by rule,

establish standards for the registration of a medical gas distributor that is not required to be licensed or registered by the state in which it is physically located.

(e) The board shall require a separate registration for each medical gas distributor located within the state and for each facility located outside of the state from which medical gases are distributed to residents of this state.

(f) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed registration for a medical gas distributor ~~unless~~, the board may require the medical gas distributor ~~passes~~ to pass an inspection conducted by an authorized representative of the board. In the case of a medical gas distributor located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 36. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) Application for a drug manufacturer license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a drug manufacturer unless the applicant agrees to operate in a manner prescribed by federal and state law and according to Minnesota Rules.

(d) No license shall be issued or renewed for a drug manufacturer that is required to be registered pursuant to United States Code, title 21, section 360, unless the applicant supplies the board with proof of registration. The board may establish by rule the standards for licensure of drug manufacturers that are not required to be registered under United States Code, title 21, section 360.

(e) No license shall be issued or renewed for a drug manufacturer that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule,

standards for the licensure of a drug manufacturer that is not required to be licensed or registered by the state in which it is physically located.

(f) The board shall require a separate license for each facility located within the state at which drug manufacturing occurs and for each facility located outside of the state at which drugs that are shipped into the state are manufactured.

(g) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed license for a drug manufacturing facility ~~unless~~, the board may require the facility ~~passes an~~ to pass a current good manufacturing practices inspection conducted by an authorized representative of the board. In the case of a drug manufacturing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by the United States Food and Drug Administration, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 37. Minnesota Statutes 2018, section 151.252, subdivision 1a, is amended to read:

Subd. 1a. **Outsourcing facility.** (a) No person shall act as an outsourcing facility without first obtaining a license from the board and paying any applicable manufacturer licensing fee specified in section 151.065.

(b) Application for an outsourcing facility license under this section shall be made in a manner specified by the board and may differ from the application required of other drug manufacturers.

(c) No license shall be issued or renewed for an outsourcing facility unless the applicant agrees to operate in a manner prescribed for outsourcing facilities by federal and state law and according to Minnesota Rules.

(d) No license shall be issued or renewed for an outsourcing facility unless the applicant supplies the board with proof of such registration by the United States Food and Drug Administration as required by United States Code, title 21, section 353b.

(e) No license shall be issued or renewed for an outsourcing facility that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of such licensure or registration. The board may establish, by

rule, standards for the licensure of an outsourcing facility that is not required to be licensed or registered by the state in which it is physically located.

(f) The board shall require a separate license for each outsourcing facility located within the state and for each outsourcing facility located outside of the state at which drugs that are shipped into the state are prepared.

(g) The board shall not issue an initial or renewed license for an outsourcing facility unless the facility passes ~~an~~ a current good manufacturing practices inspection conducted by an authorized representative of the board. In the case of an outsourcing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by the United States Food and Drug Administration, of ~~an~~ a current good manufacturing practices inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 38. Minnesota Statutes 2018, section 151.252, subdivision 3, is amended to read:

Subd. 3. **Payment to practitioner; reporting.** Unless prohibited by United States Code, title 42, section 1320a-7h, a drug manufacturer or outsourcing facility shall file with the board an annual report, in a form and on the date prescribed by the board, identifying all payments, honoraria, reimbursement, or other compensation authorized under section 151.461, clauses (4) and (5), paid to practitioners in Minnesota during the preceding calendar year. The report shall identify the nature and value of any payments totaling $100 or more to a particular practitioner during the year, and shall identify the practitioner. Reports filed under this subdivision are public data.

Sec. 39. Minnesota Statutes 2018, section 151.253, is amended by adding a subdivision to read:

Subd. 4. **Emergency veterinary compounding.** A pharmacist working within a pharmacy licensed by the board in the veterinary pharmacy license category may compound and provide a drug product to a veterinarian without first receiving a patient-specific prescription only when:

(1) the compounded drug product is needed to treat animals in urgent or emergency situations, meaning where the health of an animal is threatened, or where suffering or death of an animal is likely to result from failure to immediately treat;

(2) timely access to a compounding pharmacy is not available, as determined by the prescribing veterinarian;

(3) there is no commercially manufactured drug, approved by the United States Food and Drug Administration, that is suitable for treating the animal, or there is a documented shortage of such drug;

(4) the compounded drug is to be administered by a veterinarian or a bona fide employee of the veterinarian, or dispensed to a client of a veterinarian in an amount not to exceed what is necessary to treat an animal for a period of ten days;

(5) the pharmacy has selected the sterile or nonsterile compounding license category, in addition to the veterinary pharmacy licensing category; and

(6) the pharmacy is appropriately registered by the United States Drug Enforcement Administration when providing compounded products that contain controlled substances.

Sec. 40. Minnesota Statutes 2018, section 151.32, is amended to read:

151.32 CITATION.

The title of sections 151.01 to ~~151.40~~ 151.58 shall be the Pharmacy Practice and Wholesale Distribution Act.

Sec. 41. Minnesota Statutes 2018, section 151.40, subdivision 1, is amended to read:

Subdivision 1. **Generally.** ~~Except as otherwise provided in subdivision 2,~~ It is unlawful for any person to possess, control, manufacture, sell, furnish, dispense, or otherwise dispose of hypodermic syringes or needles or any instrument or implement which can be adapted for subcutaneous injections, except ~~by~~ for:

(1) The following persons when acting in the course of their practice or employment:

(i) licensed practitioners~~, registered~~ and their employees, agents, or delegates;

(ii) licensed pharmacies and their employees or agents~~,~~;

(iii) licensed pharmacists~~, licensed doctors of veterinary medicine or their assistants,~~;

(iv) registered nurses~~,~~ and licensed practical nurses;

(v) registered medical technologists~~,~~;

(vi) medical interns~~,~~ and residents;

(vii) licensed drug wholesalers~~,~~ and their employees or agents~~,~~;

(viii) licensed hospitals~~,~~;

(ix) bona fide hospitals in which animals are treated;

(x) licensed nursing homes~~, bona fide hospitals where animals are treated,~~;

(xi) licensed morticians~~,~~;

(xii) syringe and needle manufacturers~~,~~ and their dealers and agents~~,~~;

(xiii) persons engaged in animal husbandry~~,~~;

(xiv) clinical laboratories and their employees~~,~~;

(xv) persons engaged in bona fide research or education or industrial use of hypodermic syringes and needles provided such persons cannot use hypodermic syringes and needles for the administration of drugs to human beings unless such drugs are prescribed, dispensed, and administered by a person lawfully authorized to do so~~,~~; and

(xvi) persons who administer drugs pursuant to an order or direction of a licensed ~~doctor of medicine or of a licensed doctor of osteopathic medicine duly licensed to practice medicine.~~ practitioner;

(2) a person who self-administers drugs pursuant to either the prescription or the direction of a practitioner, or a family member, caregiver, or other individual who is designated by such person to assist the person in obtaining and using needles and syringes for the administration of such drugs;

(3) a person who is disposing of hypodermic syringes and needles through an activity or program developed under section 325F.785; or

(4) a person who sells, possesses, or handles hypodermic syringes and needles pursuant to subdivision 2.

Sec. 42. Minnesota Statutes 2018, section 151.40, subdivision 2, is amended to read:

Subd. 2. **Sales of limited quantities of clean needles and syringes.** (a) A registered pharmacy ~~or its agent~~ or a licensed pharmacist may sell, without ~~a~~ the prescription or direction of a practitioner, unused hypodermic needles and syringes in quantities of ten or fewer, provided the pharmacy or pharmacist complies with all of the requirements of this subdivision.

(b) At any location where hypodermic needles and syringes are kept for retail sale under this subdivision, the needles and syringes shall be stored in a manner that makes them available only to authorized personnel and not openly available to customers.

~~(c) No registered pharmacy or licensed pharmacist may advertise to the public the availability for retail sale, without a prescription, of hypodermic needles or syringes in quantities of ten or fewer.~~

~~(d)~~ (c) A registered pharmacy or licensed pharmacist that sells hypodermic needles or syringes under this subdivision may give the purchaser the materials developed by the commissioner of health under section 325F.785.

~~(e)~~ (d) A registered pharmacy or licensed pharmacist that sells hypodermic needles or syringes under this subdivision must certify to the commissioner of health participation in an activity, including but not limited to those developed under section 325F.785, that supports proper disposal of used hypodermic needles or syringes.

Sec. 43. Minnesota Statutes 2018, section 151.43, is amended to read:

151.43 SCOPE.

Sections ~~151.42~~ 151.43 to 151.51 apply to any person~~, partnership, corporation, or business firm~~ engaging in the wholesale distribution of ~~prescription~~ drugs within the state, and to persons operating as third-party logistics providers.

Sec. 44. **[151.441] DEFINITIONS.**

Subdivision 1. **Scope.** As used in sections 151.43 to 151.51, the following terms have the meanings given in this section.

Subd. 2. **Dispenser.** "Dispenser" means a retail pharmacy, hospital pharmacy, a group of chain pharmacies under common ownership and control that do not act as a wholesale distributor, or any other person authorized by law to dispense or administer prescription drugs, and the affiliated warehouses or distribution centers of such entities under common ownership and control that do not act as a wholesale distributor, but does not include a person who dispenses only products to be used in animals in accordance with United States Code, title 21, section 360b(a)(5).

Subd. 3. **Disposition.** "Disposition," with respect to a product within the possession or control of an entity, means the removal of such product from the pharmaceutical distribution supply chain, which may include disposal or return of the product for disposal or other appropriate handling and other actions, such as retaining a sample of the product for further

additional physical examination or laboratory analysis of the product by a manufacturer or regulatory or law enforcement agency.

Subd. 4. **Distribute or distribution.** "Distribute" or "distribution" means the sale, purchase, trade, delivery, handling, storage, or receipt of a product, and does not include the dispensing of a product pursuant to a prescription executed in accordance with United States Code, title 21, section 353(b)(1), or the dispensing of a product approved under United States Code, title 21, section 360b(b).

Subd. 5. **Manufacturer.** "Manufacturer" means, with respect to a product:

(1) a person who holds an application approved under United States Code, title 21, section 355, or a license issued under United States Code, title 42, section 262, for such product, or if such product is not the subject of an approved application or license, the person who manufactured the product;

(2) a co-licensed partner of the person described in clause (1) that obtains the product directly from a person described in this subdivision; or

(3) an affiliate of a person described in clause (1) or (2) that receives the product directly from a person described in this subdivision.

Subd. 6. **Medical convenience kit.** "Medical convenience kit" means a collection of finished medical devices, which may include a product or biological product, assembled in kit form strictly for the convenience of the purchaser or user.

Subd. 7. **Package.** "Package" means the smallest individual salable unit of product for distribution by a manufacturer or repackager that is intended by the manufacturer for ultimate sale to the dispenser of such product. For purposes of this subdivision, an "individual salable unit" is the smallest container of product introduced into commerce by the manufacturer or repackager that is intended by the manufacturer or repackager for individual sale to a dispenser.

Subd. 8. **Prescription drug.** "Prescription drug" means a drug for human use subject to United States Code, title 21, section 353(b)(1).

Subd. 9. **Product.** "Product" means a prescription drug in a finished dosage form for administration to a patient without substantial further manufacturing, but does not include blood or blood components intended for transfusion; radioactive drugs or radioactive biological products as defined in Code of Federal Regulations, title 21, section 600.3(ee), that are regulated by the Nuclear Regulatory Commission or by a state pursuant to an agreement with such commission under United States Code, title 42, section 2021; imaging

drugs; an intravenous product described in subdivision 12, paragraph (b), clauses (14) to (16); any medical gas defined in United States Code, title 21, section 360ddd; homeopathic drugs marketed in accordance with applicable federal law; or a drug compounded in compliance with United States Code, title 21, section 353a or 353b.

Subd. 10. **Repackager.** "Repackager" means a person who owns or operates an establishment that repacks and relabels a product or package for further sale or for distribution without a further transaction.

Subd. 11. **Third-party logistics provider.** "Third-party logistics provider" means an entity that provides or coordinates warehousing or other logistics services of a product in interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a product, but does not take ownership of the product nor have responsibility to direct the sale or disposition of the product.

Subd. 12. **Transaction.** (a) "Transaction" means the transfer of product between persons in which a change of ownership occurs.

(b) The term "transaction" does not include:

(1) intracompany distribution of any product between members of an affiliate or within a manufacturer;

(2) the distribution of a product among hospitals or other health care entities that are under common control;

(3) the distribution of a drug or an offer to distribute a drug for emergency medical reasons, including:

(i) a public health emergency declaration pursuant to United States Code, title 42, section 247d;

(ii) a national security or peacetime emergency declared by the governor pursuant to section 12.31; or

(iii) a situation involving an action taken by the commissioner of health pursuant to section 144.4197, 144.4198 or 151.37, subdivisions 2, paragraph (b), and 10, except that, for purposes of this paragraph, a drug shortage not caused by a public health emergency shall not constitute an emergency medical reason;

(4) the dispensing of a drug pursuant to a valid prescription issued by a licensed practitioner;

(5) the distribution of product samples by a manufacturer or a licensed wholesale distributor in accordance with United States Code, title 21, section 353(d);

(6) the distribution of blood or blood components intended for transfusion;

(7) the distribution of minimal quantities of product by a licensed retail pharmacy to a licensed practitioner for office use;

(8) the sale, purchase, or trade of a drug or an offer to sell, purchase, or trade a drug by a charitable organization described in United States Code, title 26, section 501(c)(3), to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

(9) the distribution of a product pursuant to the sale or merger of a pharmacy or pharmacies or a wholesale distributor or wholesale distributors, except that any records required to be maintained for the product shall be transferred to the new owner of the pharmacy or pharmacies or wholesale distributor or wholesale distributors;

(10) the dispensing of a product approved under United States Code, title 21, section 360b(c);

(11) transfer of products to or from any facility that is licensed by the Nuclear Regulatory Commission or by a state pursuant to an agreement with such commission under United States Code, title 42, section 2021;

(12) transfer of a combination product that is not subject to approval under United States Code, title 21, section 355, or licensure under United States Code, title 42, section 262, and that is:

(i) a product comprised of a device and one or more other regulated components (such as a drug/device, biologic/device, or drug/device/biologic) that are physically, chemically, or otherwise combined or mixed and produced as a single entity;

(ii) two or more separate products packaged together in a single package or as a unit and comprised of a drug and device or device and biological product; or

(iii) two or more finished medical devices plus one or more drug or biological products that are packaged together in a medical convenience kit;

(13) the distribution of a medical convenience kit if:

(i) the medical convenience kit is assembled in an establishment that is registered with the Food and Drug Administration as a device manufacturer in accordance with United States Code, title 21, section 360(b)(2);

(ii) the medical convenience kit does not contain a controlled substance that appears in a schedule contained in the Comprehensive Drug Abuse Prevention and Control Act of 1970, United States Code, title 21, section 801, et seq.;

(iii) in the case of a medical convenience kit that includes a product, the person who manufactures the kit:

(A) purchased the product directly from the pharmaceutical manufacturer or from a wholesale distributor that purchased the product directly from the pharmaceutical manufacturer; and

(B) does not alter the primary container or label of the product as purchased from the manufacturer or wholesale distributor; and

(iv) in the case of a medical convenience kit that includes a product, the product is:

(A) an intravenous solution intended for the replenishment of fluids and electrolytes;

(B) a product intended to maintain the equilibrium of water and minerals in the body;

(C) a product intended for irrigation or reconstitution;

(D) an anesthetic;

(E) an anticoagulant;

(F) a vasopressor; or

(G) a sympathomimetic;

(14) the distribution of an intravenous product that, by its formulation, is intended for the replenishment of fluids and electrolytes, such as sodium, chloride, and potassium; or calories, such as dextrose and amino acids;

(15) the distribution of an intravenous product used to maintain the equilibrium of water and minerals in the body, such as dialysis solutions;

(16) the distribution of a product that is intended for irrigation, or sterile water, whether intended for such purposes or for injection;

(17) the distribution of a medical gas as defined in United States Code, title 21, section 360ddd; or

(18) the distribution or sale of any licensed product under United States Code, title 42, section 262, that meets the definition of a device under United States Code, title 21, section 321(h).

Subd. 13. **Wholesale distribution.** "Wholesale distribution" means the distribution of a drug to a person other than a consumer or patient, or receipt of a drug by a person other than the consumer or patient, but does not include:

(1) intracompany distribution of any drug between members of an affiliate or within a manufacturer;

(2) the distribution of a drug or an offer to distribute a drug among hospitals or other health care entities that are under common control;

(3) the distribution of a drug or an offer to distribute a drug for emergency medical reasons, including:

(i) a public health emergency declaration pursuant to United States Code, title 42, section 247d;

(ii) a national security or peacetime emergency declared by the governor pursuant to section 12.31; or

(iii) a situation involving an action taken by the commissioner of health pursuant to sections 144.4197, 144.4198 or 151.37, subdivisions 2, paragraph (b), and 10, except that, for purposes of this paragraph, a drug shortage not caused by a public health emergency shall not constitute an emergency medical reason;

(4) the dispensing of a drug pursuant to a valid prescription issued by a licensed practitioner;

(5) the distribution of minimal quantities of a drug by a licensed retail pharmacy to a licensed practitioner for office use;

(6) the distribution of a drug or an offer to distribute a drug by a charitable organization to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

(7) the purchase or other acquisition by a dispenser, hospital, or other health care entity of a drug for use by such dispenser, hospital, or other health care entity;

(8) the distribution of a drug by the manufacturer of such drug;

(9) the receipt or transfer of a drug by an authorized third-party logistics provider provided that such third-party logistics provider does not take ownership of the drug;

(10) a common carrier that transports a drug, provided that the common carrier does not take ownership of the drug;

(11) the distribution of a drug or an offer to distribute a drug by an authorized repackager that has taken ownership or possession of the drug and repacks it in accordance with United States Code, title 21, section 360eee-1(e);

(12) salable drug returns when conducted by a dispenser;

(13) the distribution of a collection of finished medical devices, which may include a product or biological product, assembled in kit form strictly for the convenience of the purchaser or user, referred to in this section as a medical convenience kit, if:

(i) the medical convenience kit is assembled in an establishment that is registered with the Food and Drug Administration as a device manufacturer in accordance with United States Code, title 21, section 360(b)(2);

(ii) the medical convenience kit does not contain a controlled substance that appears in a schedule contained in the Comprehensive Drug Abuse Prevention and Control Act of 1970, United States Code, title 21, section 801, et seq.;

(iii) in the case of a medical convenience kit that includes a product, the person that manufactures the kit:

(A) purchased such product directly from the pharmaceutical manufacturer or from a wholesale distributor that purchased the product directly from the pharmaceutical manufacturer; and

(B) does not alter the primary container or label of the product as purchased from the manufacturer or wholesale distributor; and

(iv) in the case of a medical convenience kit that includes a product, the product is:

(A) an intravenous solution intended for the replenishment of fluids and electrolytes;

(B) a product intended to maintain the equilibrium of water and minerals in the body;

(C) a product intended for irrigation or reconstitution;

(D) an anesthetic;

(E) an anticoagulant;

(F) a vasopressor; or

(G) a sympathomimetic;

(14) the distribution of an intravenous drug that, by its formulation, is intended for the replenishment of fluids and electrolytes, such as sodium, chloride, and potassium; or calories, such as dextrose and amino acids;

(15) the distribution of an intravenous drug used to maintain the equilibrium of water and minerals in the body, such as dialysis solutions;

(16) the distribution of a drug that is intended for irrigation, or sterile water, whether intended for such purposes or for injection;

(17) the distribution of medical gas, as defined in United States Code, title 21, section 360ddd;

(18) facilitating the distribution of a product by providing solely administrative services, including processing of orders and payments; or

(19) the transfer of a product by a hospital or other health care entity, or by a wholesale distributor or manufacturer operating at the direction of the hospital or other health care entity, to a repackager described in United States Code, title 21, section 360eee(16)(B), and registered under United States Code, title 21, section 360, for the purpose of repackaging the drug for use by that hospital, or other health care entity and other health care entities that are under common control, if ownership of the drug remains with the hospital or other health care entity at all times.

Subd. 14. **Wholesale distributor.** "Wholesale distributor" means a person engaged in wholesale distribution but does not include a manufacturer, a manufacturer's co-licensed partner, a third-party logistics provider, or a repackager.

Sec. 45. Minnesota Statutes 2018, section 151.46, is amended to read:

151.46 PROHIBITED DRUG PURCHASES OR RECEIPT.

It is unlawful for any person to knowingly purchase or receive a prescription drug from a source other than a person or entity licensed under the laws of the state, except where otherwise provided. Licensed wholesale drug distributors ~~other than pharmacies~~ and licensed third-party logistics providers shall not dispense or distribute ~~prescription~~ drugs directly to patients. A person violating the provisions of this section is guilty of a misdemeanor.

Sec. 46. Minnesota Statutes 2018, section 151.47, subdivision 1, is amended to read:

Subdivision 1. ~~**Requirements**~~ **Generally.** ~~(a) All wholesale drug distributors are subject to the requirements of this subdivision.~~ Each manufacturer, repackager, wholesale distributor, and dispenser shall comply with the requirements set forth in United States Code, title 21, section 360eee-1, with respect to the role of such manufacturer, repackager, wholesale distributor, or dispenser in a transaction involving a product. If an entity meets the definition of more than one of the entities listed in the preceding sentence, such entity shall comply

with all applicable requirements in United States Code, title 21, section 360eee-1, but shall not be required to duplicate requirements.

~~(b) No person or distribution outlet shall act as a wholesale drug distributor without first obtaining a license from the board and paying any applicable fee specified in section 151.065.~~

~~(c) Application for a wholesale drug distributor license under this section shall be made in a manner specified by the board.~~

~~(d) No license shall be issued or renewed for a wholesale drug distributor to operate unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.~~

~~(e) No license may be issued or renewed for a drug wholesale distributor that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule, standards for the licensure of a drug wholesale distributor that is not required to be licensed or registered by the state in which it is physically located.~~

~~(f) The board shall require a separate license for each drug wholesale distributor facility located within the state and for each drug wholesale distributor facility located outside of the state from which drugs are shipped into the state or to which drugs are reverse distributed.~~

~~(g) The board shall not issue an initial or renewed license for a drug wholesale distributor facility unless the facility passes an inspection conducted by an authorized representative of the board, or is accredited by an accreditation program approved by the board. In the case of a drug wholesale distributor facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board, or furnishes the board with proof of current accreditation. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.~~

~~(h) As a condition for receiving and retaining a wholesale drug distributor license issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has and will continuously maintain:~~

~~(1) adequate storage conditions and facilities;~~

~~(2) minimum liability and other insurance as may be required under any applicable federal or state law;~~

~~(3) a viable security system that includes an after hours central alarm, or comparable entry detection capability; restricted access to the premises; comprehensive employment applicant screening; and safeguards against all forms of employee theft;~~

~~(4) a system of records describing all wholesale drug distributor activities set forth in section 151.44 for at least the most recent two-year period, which shall be reasonably accessible as defined by board regulations in any inspection authorized by the board;~~

~~(5) principals and persons, including officers, directors, primary shareholders, and key management executives, who must at all times demonstrate and maintain their capability of conducting business in conformity with sound financial practices as well as state and federal law;~~

~~(6) complete, updated information, to be provided to the board as a condition for obtaining and retaining a license, about each wholesale drug distributor to be licensed, including all pertinent corporate licensee information, if applicable, or other ownership, principal, key personnel, and facilities information found to be necessary by the board;~~

~~(7) written policies and procedures that assure reasonable wholesale drug distributor preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or product shipping and receiving, outdated product or other unauthorized product control, appropriate disposition of returned goods, and product recalls;~~

~~(8) sufficient inspection procedures for all incoming and outgoing product shipments;~~ ~~and~~

~~(9) operations in compliance with all federal requirements applicable to wholesale drug distribution.~~

~~(i) An agent or employee of any licensed wholesale drug distributor need not seek licensure under this section.~~

Sec. 47. Minnesota Statutes 2018, section 151.47, is amended by adding a subdivision to read:

Subd. 1a. **Licensing.** (a) The board shall license wholesale distributors in a manner that is consistent with United States Code, title 21, section 360eee-2, and the regulations

promulgated thereunder. In the event that the provisions of this section, or of the rules of the board, conflict with the provisions of United States Code, title 21, section 360eee-2, or the rules promulgated thereunder, the federal provisions shall prevail. The board shall not license a person as a wholesale distributor unless the person is engaged in wholesale distribution.

(b) No person shall act as a wholesale distributor without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(c) Application for a wholesale distributor license under this section shall be made in a manner specified by the board.

(d) No license shall be issued or renewed for a wholesale distributor unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.

(e) No license may be issued or renewed for a wholesale distributor facility that is located in another state unless the applicant supplies the board with proof of licensure or registration by the state in which the wholesale distributor is physically located or by the United States Food and Drug Administration.

(f) The board shall require a separate license for each drug wholesale distributor facility located within the state and for each drug wholesale distributor facility located outside of the state from which drugs are shipped into the state or to which drugs are reverse distributed.

(g) The board shall not issue an initial or renewed license for a drug wholesale distributor facility unless the facility passes an inspection conducted by an authorized representative of the board or is inspected and accredited by an accreditation program approved by the board. In the case of a drug wholesale distributor facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board, or furnishes the board with proof of current accreditation. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(h) As a condition for receiving and retaining a wholesale drug distributor license issued under this section, an applicant shall satisfy the board that it:

(1) has adequate storage conditions and facilities to allow for the safe receipt, storage, handling, and sale of drugs;

(2) has minimum liability and other insurance as may be required under any applicable federal or state law;

(3) has a functioning security system that includes an after-hours central alarm or comparable entry detection capability, and security policies and procedures that include provisions for restricted access to the premises, comprehensive employee applicant screening, and safeguards against all forms of employee theft;

(4) will maintain appropriate records of the distribution of drugs, which shall be kept for a minimum of two years and be made available to the board upon request;

(5) employs principals and other persons, including officers, directors, primary shareholders, and key management executives, who will at all times demonstrate and maintain their capability of conducting business in conformity with state and federal law, at least one of whom will serve as the primary designated representative for each licensed facility and who will be responsible for ensuring that the facility operates in a manner consistent with state and federal law;

(6) will ensure that all personnel have sufficient education, training, and experience, in any combination, so that they may perform assigned duties in a manner that maintains the quality, safety, and security of drugs;

(7) will provide the board with updated information about each wholesale distributor facility to be licensed, as requested by the board;

(8) will develop and, as necessary, update written policies and procedures that assure reasonable wholesale drug distributor preparation for, protection against, and handling of any facility security or operation problems, including but not limited to those caused by natural disaster or government emergency, inventory inaccuracies or drug shipping and receiving, outdated drugs, appropriate handling of returned goods, and drug recalls;

(9) will have sufficient policies and procedures in place for the inspection of all incoming and outgoing drug shipments;

(10) will operate in compliance with all state and federal requirements applicable to wholesale drug distribution; and

(11) will meet the requirements for inspections found in this subdivision.

(i) An agent or employee of any licensed wholesale drug distributor need not seek licensure under this section. Paragraphs (i) to (p) apply to wholesaler personnel.

(j) The board is authorized to and shall require fingerprint-based criminal background checks of facility managers or designated representatives, as required under United States Code, title 21, section 360eee-2. The criminal background checks shall be conducted as provided in section 214.075. The board shall use the criminal background check data received to evaluate the qualifications of persons for ownership of or employment by a licensed wholesaler and shall not disseminate this data except as allowed by law.

(k) A licensed wholesaler shall not be owned by, or employ, a person who has:

(1) been convicted of any felony for conduct relating to wholesale distribution, any felony violation of United States Code, title 21, section 331, subsections (i) or (k), or any felony violation of United States Code, title 18, section 1365, relating to product tampering; or

(2) engaged in a pattern of violating the requirements of United States Code, title 21, section 360eee-2, or the regulations promulgated thereunder, or state requirements for licensure, that presents a threat of serious adverse health consequences or death to humans.

(l) An applicant for the issuance or renewal of a wholesale distributor license shall execute and file with the board a surety bond.

(m) Prior to issuing or renewing a wholesale distributor license, the board shall require an applicant that is not a government owned and operated wholesale distributor to submit a surety bond of $100,000, except that if the annual gross receipts of the applicant for the previous tax year is $10,000,000 or less, a surety bond of $25,000 shall be required.

(n) If a wholesale distributor can provide evidence satisfactory to the board that it possesses the required bond in another state, the requirement for a bond shall be waived.

(o) The purpose of the surety bond required under this subdivision is to secure payment of any civil penalty imposed by the board pursuant to section 151.071, subdivision 1. The board may make a claim against the bond if the licensee fails to pay a civil penalty within 30 days after the order imposing the fine or costs become final.

(p) A single surety bond shall satisfy the requirement for the submission of a bond for all licensed wholesale distributor facilities under common ownership.

Sec. 48. **[151.471] THIRD-PARTY LOGISTICS PROVIDER REQUIREMENTS.**

Subdivision 1. **Generally.** Each third-party logistics provider shall comply with the requirements set forth in United States Code, title 21, section 360eee to 360eee-4, that are applicable to third-party logistics providers.

Subd. 2. **Licensing.** (a) The board shall license third-party logistics providers in a manner that is consistent with United States Code, title 21, section 360eee-3, and the regulations promulgated thereunder. In the event that the provisions of this section or of the rules of the board conflict with the provisions of United States Code, title 21, section 360eee-3, or the rules promulgated thereunder, the federal provisions shall prevail. The board shall not license a person as a third-party logistics provider unless the person is operating as such.

(b) No person shall act as a third-party logistics provider without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(c) Application for a third-party logistics provider license under this section shall be made in a manner specified by the board.

(d) No license shall be issued or renewed for a third-party logistics provider unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.

(e) No license may be issued or renewed for a third-party logistics provider facility that is located in another state unless the applicant supplies the board with proof of licensure or registration by the state in which the third-party logistics provider facility is physically located or by the United States Food and Drug Administration.

(f) The board shall require a separate license for each third-party logistics provider facility located within the state and for each third-party logistics provider facility located outside of the state from which drugs are shipped into the state or to which drugs are reverse distributed.

(g) The board shall not issue an initial or renewed license for a third-party logistics provider facility unless the facility passes an inspection conducted by an authorized representative of the board or is inspected and accredited by an accreditation program approved by the board. In the case of a third-party logistics provider facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the

license application by the board, or furnishes the board with proof of current accreditation. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(h) As a condition for receiving and retaining a third-party logistics provider facility license issued under this section, an applicant shall satisfy the board that it:

(1) has adequate storage conditions and facilities to allow for the safe receipt, storage, handling, and transfer of drugs;

(2) has minimum liability and other insurance as may be required under any applicable federal or state law;

(3) has a functioning security system that includes an after-hours central alarm or comparable entry detection capability, and security policies and procedures that include provisions for restricted access to the premises, comprehensive employee applicant screening, and safeguards against all forms of employee theft;

(4) will maintain appropriate records of the handling of drugs, which shall be kept for a minimum of two years and be made available to the board upon request;

(5) employs principals and other persons, including officers, directors, primary shareholders, and key management executives, who will at all times demonstrate and maintain their capability of conducting business in conformity with state and federal law, at least one of whom will serve as the primary designated representative for each licensed facility and who will be responsible for ensuring that the facility operates in a manner consistent with state and federal law;

(6) will ensure that all personnel have sufficient education, training, and experience, in any combination, so that they may perform assigned duties in a manner that maintains the quality, safety, and security of drugs;

(7) will provide the board with updated information about each third-party logistics provider facility to be licensed by the board;

(8) will develop and, as necessary, update written policies and procedures that ensure reasonable preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or drug shipping and receiving, outdated drug, appropriate handling of returned goods, and drug recalls;

(9) will have sufficient policies and procedures in place for the inspection of all incoming and outgoing drug shipments;

(10) will operate in compliance with all state and federal requirements applicable to third-party logistics providers; and

(11) will meet the requirements for inspections found in this subdivision.

(i) An agent or employee of any licensed third-party logistics provider need not seek licensure under this section. Paragraphs (j) and (k) apply to third-party logistics provider personnel.

(j) The board is authorized to and shall require fingerprint-based criminal background checks of facility managers or designated representatives. The criminal background checks shall be conducted as provided in section 214.075. The board shall use the criminal background check data received to evaluate the qualifications of persons for ownership of or employment by a licensed third-party logistics provider and shall not disseminate this data except as allowed by law.

(k) A licensed third-party logistics provider shall not have as a facility manager or designated representative any person who has been convicted of any felony for conduct relating to wholesale distribution, any felony violation of United States Code, title 21, section 331, subsection (i) or (k), or any felony violation of United States Code, title 18, section 1365, relating to product tampering.

Sec. 49. Minnesota Statutes 2018, section 152.126, subdivision 6, is amended to read:

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:

(i) prescribing or considering prescribing any controlled substance;

(ii) providing emergency medical treatment for which access to the data may be necessary;

(iii) providing care, and the prescriber has reason to believe, based on clinically valid indications, that the patient is potentially abusing a controlled substance; or

(iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber who is requesting data in accordance with clause (1);

(4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

(5) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is impaired by use of a drug for which data is collected under subdivision 4, has engaged in activity that would constitute a crime as defined in section 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

(6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(7) authorized personnel of a vendor under contract with the state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);

(8) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;

(9) personnel of the Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital;

(10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (i);

(11) personnel of the health professionals services program established under section 214.31, to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3.

For purposes of clause (4), access by an individual includes persons in the definition of an individual under section 13.02; and

(12) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is inappropriately prescribing controlled substances as defined in this section.

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

(d) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), may directly access the data electronically. No other permissible users may directly access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible

user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(e) The board shall not release data submitted under subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

(f) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph ~~(c)~~ (d) prior to attaining direct access to the data.

(g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

(h) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph.

(i) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34, paragraph (c), prior to implementing this paragraph.

(j) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met.

(k) The board shall conduct random audits, on at least a quarterly basis, of electronic access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), to the data in subdivision 4, to ensure compliance with permissible use as defined in this section. A permissible user whose account has been selected for a random audit shall respond to an inquiry by the board, no later than 30 days after receipt of notice that an audit is being conducted. Failure to respond may result in deactivation of access to the electronic system and referral to the appropriate health licensing board, or the commissioner of human services, for further action. The board shall report the results of random audits to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and government data practices.

(l) A permissible user who has delegated the task of accessing the data in subdivision 4 to an agent or employee shall audit the use of the electronic system by delegated agents or employees on at least a quarterly basis to ensure compliance with permissible use as defined in this section. When a delegated agent or employee has been identified as inappropriately accessing data, the permissible user must immediately remove access for that individual and notify the board within seven days. The board shall notify all permissible users associated with the delegated agent or employee of the alleged violation.

(m) A permissible user who delegates access to the data submitted under subdivision 4 to an agent or employee shall terminate that individual's access to the data within three business days of the agent or employee leaving employment with the permissible user. The board may conduct random audits to determine compliance with this requirement.

Sec. 50. Minnesota Statutes 2018, section 152.126, subdivision 7, is amended to read:

Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.

(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of health care data shall be subject to disciplinary action by the appropriate health-related licensing board, and appropriate civil penalties.

(c) A prescriber or dispenser authorized to access the data who fails to comply with subdivision 6, paragraph (l) or (m), shall be subject to disciplinary action by the appropriate health-related licensing board.

Sec. 51. Minnesota Statutes 2018, section 152.126, is amended by adding a subdivision to read:

Subd. 10a. **Patient information on record access.** A patient who has been prescribed a controlled substance may access the prescription monitoring program database in order to obtain information on access by permissible users to the patient's data record, including the name and organizational affiliation of the permissible user and the date of access. In order to obtain this information, the patient must complete, notarize, and submit a request form developed by the board. The board shall make this form available to the public on the board's website.

Sec. 52. **REVISOR INSTRUCTION.**

The fee increases in Minnesota Statutes, section 151.065, subdivisions 1 and 3, in this article are in addition to any other fee increases in Minnesota Statutes, section 151.065, subdivisions 1 and 3, enacted in 2019 regular or special sessions. If multiple fees are enacted, the revisor of statutes shall add the fees together for publication in the 2019 Minnesota Statutes Supplement to effectuate the intent of the legislature.

Sec. 53. **REPEALER.**

(a) Minnesota Statutes 2018, sections 151.42; 151.44; 151.49; 151.50; 151.51; and 151.55, are repealed.

(b) Minnesota Rules, parts 6400.6970; 7200.6100; and 7200.6105, are repealed.

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

ARTICLE 11
HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2018, section 18K.03, is amended to read:

18K.03 AGRICULTURAL CROP; POSSESSION AUTHORIZED.

Subdivision 1. **Industrial hemp.** Industrial hemp is an agricultural crop in this state. A person may possess, transport, process, sell, or buy industrial hemp that is grown pursuant to this chapter.

Subd. 2. **Sale to medical cannabis manufacturers.** A licensee under this chapter may sell hemp products derived from industrial hemp grown in this state to medical cannabis manufacturers as authorized under sections 152.22 to 152.37.

Sec. 2. Minnesota Statutes 2018, section 62J.495, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** ~~By January 1, 2015, all hospitals and health care providers, as defined in section 62J.03, subdivision 8, must have in place an interoperable electronic health records system within their hospital system or clinical practice setting.~~ The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop ~~a statewide plan to meet this goal, including~~ uniform standards to be used for the interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. The commissioner shall include an update on standards development as part of an annual report to the legislature. Individual health care providers in private practice with no other providers and health care providers that do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

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

Sec. 3. Minnesota Statutes 2018, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) ~~To meet the requirements of subdivision 1,~~ Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a state-certified health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

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

Sec. 4. Minnesota Statutes 2018, section 103I.005, subdivision 2, is amended to read:

Subd. 2. **Boring.** "Boring" means a hole or excavation that ~~is not used to extract water and~~ includes exploratory borings, bored geothermal heat exchangers, temporary borings, and elevator borings.

Sec. 5. Minnesota Statutes 2018, section 103I.005, subdivision 8a, is amended to read:

Subd. 8a. **Environmental well.** "Environmental well" means an excavation 15 or more feet in depth that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, and includes a groundwater quality monitoring or sampling well;

(2) lower a groundwater level to control or remove contamination in groundwater, and includes a remedial well and excludes horizontal trenches; or

(3) monitor or measure physical, chemical, radiological, or biological parameters of the earth and earth fluids, or for vapor recovery or venting systems. An environmental well includes an excavation used to:

(i) measure groundwater levels, including a piezometer;

(ii) determine groundwater flow direction or velocity;

(iii) measure earth properties such as hydraulic conductivity, bearing capacity, or resistance;

(iv) obtain samples of geologic materials for testing or classification; or

(v) remove or remediate pollution or contamination from groundwater or soil through the use of a vent, vapor recovery system, or sparge point.

An environmental well does not include an exploratory boring.

Sec. 6. Minnesota Statutes 2018, section 103I.005, subdivision 17a, is amended to read:

Subd. 17a. **Temporary ~~environmental well~~ boring.** ~~"Temporary environmental well" means an environmental well as defined in section 103I.005, subdivision 8a, that is sealed within 72 hours of the time construction on the well begins.~~ "Temporary boring" means an excavation that is 15 feet or more in depth, is sealed within 72 hours of the time of construction, and is drilled, cored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, including groundwater quality monitoring;

(2) monitor or measure physical, chemical, radiological, or biological parameters of earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or resistance;

(3) measure groundwater levels, including use of a piezometer; and

(4) determine groundwater flow direction or velocity.

Sec. 7. Minnesota Statutes 2018, section 103I.205, subdivision 1, is amended to read:

Subdivision 1. **Notification required.** (a) Except as provided in paragraph (d), a person may not construct a water-supply, dewatering, or environmental well until a notification of the proposed well on a form prescribed by the commissioner is filed with the commissioner with the filing fee in section 103I.208, and, when applicable, the person has met the requirements of paragraph (e). If after filing the well notification an attempt to construct a well is unsuccessful, a new notification is not required unless the information relating to the successful well has substantially changed. A notification is not required prior to construction of a temporary ~~environmental well~~ boring.

(b) The property owner, the property owner's agent, or the licensed contractor where a well is to be located must file the well notification with the commissioner.

(c) The well notification under this subdivision preempts local permits and notifications, and counties or home rule charter or statutory cities may not require a permit or notification for wells unless the commissioner has delegated the permitting or notification authority under section 103I.111.

(d) A person who is an individual that constructs a drive point water-supply well on property owned or leased by the individual for farming or agricultural purposes or as the individual's place of abode must notify the commissioner of the installation and location of the well. The person must complete the notification form prescribed by the commissioner and mail it to the commissioner by ten days after the well is completed. A fee may not be charged for the notification. A person who sells drive point wells at retail must provide buyers with notification forms and informational materials including requirements regarding wells, their location, construction, and disclosure. The commissioner must provide the notification forms and informational materials to the sellers.

(e) When the operation of a well will require an appropriation permit from the commissioner of natural resources, a person may not begin construction of the well until the person submits the following information to the commissioner of natural resources:

(1) the location of the well;

(2) the formation or aquifer that will serve as the water source;

(3) the maximum daily, seasonal, and annual pumpage rates and volumes that will be requested in the appropriation permit; and

(4) other information requested by the commissioner of natural resources that is necessary to conduct the preliminary assessment required under section 103G.287, subdivision 1, paragraph (c).

The person may begin construction after receiving preliminary approval from the commissioner of natural resources.

Sec. 8. Minnesota Statutes 2018, section 103I.205, subdivision 4, is amended to read:

Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e), section 103I.401, subdivision 2, or 103I.601, subdivision 2, a person may not drill, construct, repair, or seal a well or boring unless the person has a well contractor's license in possession.

(b) A person may construct, repair, and seal an environmental well <u>or temporary boring</u> if the person:

(1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches of civil or geological engineering;

(2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

(3) is a professional geoscientist licensed under sections 326.02 to 326.15;

(4) is a geologist certified by the American Institute of Professional Geologists; or

(5) meets the qualifications established by the commissioner in rule.

A person must be licensed by the commissioner as an environmental well contractor on forms provided by the commissioner.

(c) A person may do the following work with a limited well/boring contractor's license in possession. A separate license is required for each of the four activities:

(1) installing, repairing, and modifying well screens, pitless units and pitless adaptors, well pumps and pumping equipment, and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing;

(2) sealing wells and borings;

(3) constructing, repairing, and sealing dewatering wells; or

(4) constructing, repairing, and sealing bored geothermal heat exchangers.

(d) A person may construct, repair, and seal an elevator boring with an elevator boring contractor's license.

(e) Notwithstanding other provisions of this chapter requiring a license, a license is not required for a person who complies with the other provisions of this chapter if the person is:

(1) an individual who constructs a water-supply well on land that is owned or leased by the individual and is used by the individual for farming or agricultural purposes or as the individual's place of abode; or

(2) an individual who performs labor or services for a contractor licensed under the provisions of this chapter in connection with the construction, sealing, or repair of a well or boring at the direction and under the personal supervision of a contractor licensed under the provisions of this chapter~~; or~~.

~~(3) a licensed plumber who is repairing submersible pumps or water pipes associated with well water systems if: (i) the repair location is within an area where there is no licensed well contractor within 50 miles, and (ii) the licensed plumber complies with all relevant sections of the plumbing code.~~

Sec. 9. Minnesota Statutes 2018, section 103I.205, subdivision 9, is amended to read:

Subd. 9. **Report of work.** Within ~~30~~ 60 days after completion or sealing of a well or boring, the person doing the work must submit a verified report to the commissioner containing the information specified by rules adopted under this chapter.

Within 30 days after receiving the report, the commissioner shall send or otherwise provide access to a copy of the report to the commissioner of natural resources, to the local soil and water conservation district where the well is located, and to the director of the Minnesota Geological Survey.

Sec. 10. Minnesota Statutes 2018, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. **Well notification fee.** The well notification fee to be paid by a property owner is:

(1) for construction of a water supply well, $275, which includes the state core function fee;

(2) for a well sealing, $75 for each well or temporary boring, which includes the state core function fee, except that: (i) a single notification and fee of $75 is required for all temporary ~~environmental wells recorded on the sealing notification for~~ borings on a single property~~, having depths within a 25 foot range,~~ and sealed within 72 hours of start of construction; and (ii) temporary borings less than 25 feet in depth are exempt from the notification and fee requirements in this chapter;

(3) for construction of a dewatering well, $275, which includes the state core function fee, for each dewatering well except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of $1,375 for the dewatering wells recorded on the notification; and

(4) for construction of an environmental well, $275, which includes the state core function fee, except that a single fee of $275 is required for all environmental wells recorded on the notification that are located on a single property, and except that no fee is required for construction of a temporary ~~environmental well~~ boring.

Sec. 11. Minnesota Statutes 2018, section 103I.235, subdivision 3, is amended to read:

Subd. 3. **Temporary ~~environmental well~~ boring and unsuccessful well exemption.** This section does not apply to temporary ~~environmental wells~~ borings or unsuccessful wells that have been sealed by a licensed contractor in compliance with this chapter.

Sec. 12. Minnesota Statutes 2018, section 103I.301, is amended by adding a subdivision to read:

Subd. 3a. **Temporary boring.** (a) The owner of the property where a temporary boring is located must have the temporary boring sealed within 72 hours after the start of construction of the temporary boring.

(b) The owner must have a well contractor, a limited well/boring sealing contractor, or an environmental well contractor seal the temporary boring.

Sec. 13. Minnesota Statutes 2018, section 103I.301, subdivision 6, is amended to read:

Subd. 6. **Notification required.** A person may not seal a well or temporary boring until a notification of the proposed sealing is filed as prescribed by the commissioner. A single notification is required for all temporary borings sealed on a single property. Temporary borings less than 25 feet in depth are exempt from the notification requirements in this chapter.

Sec. 14. Minnesota Statutes 2018, section 103I.601, subdivision 4, is amended to read:

Subd. 4. **Notification and map of borings.** (a) By ten days before beginning exploratory boring, an explorer must submit to the commissioner of health a notification of the proposed boring ~~on a form prescribed by the commissioner,~~ map and a fee of $275 ~~for each exploratory boring~~.

(b) By ten days before beginning exploratory boring, an explorer must submit to the commissioners of health and natural resources a county road map on a single sheet of paper that is 8-1/2 by 11 inches in size and having a scale of one-half inch equal to one mile, as prepared by the Department of Transportation, or a 7.5 minute series topographic map (1:24,000 scale), as prepared by the United States Geological Survey, showing the location of each proposed exploratory boring to the nearest estimated 40 acre parcel. Exploratory boring that is proposed on the map may not be commenced later than 180 days after submission of the map, unless a new map is submitted.

Sec. 15. Minnesota Statutes 2018, section 144.121, subdivision 1a, is amended to read:

Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing radiation-producing equipment must pay an annual initial or annual renewal registration fee consisting of a base facility fee of $100 and an additional fee for each radiation source, as follows:

(1) medical or veterinary equipment	$	100
(2) dental x-ray equipment	$	40
(3) x-ray equipment not used on humans or animals	$	100
(4) devices with sources of ionizing radiation not used on humans or animals	$	100
(5) security screening system	$	100

(b) A facility with radiation therapy and accelerator equipment must pay an annual registration fee of $500. A facility with an industrial accelerator must pay an annual registration fee of $150.

(c) Electron microscopy equipment is exempt from the registration fee requirements of this section.

(d) For purposes of this section, a security screening system means radiation-producing equipment designed and used for security screening of humans who are in the custody of a correctional or detention facility, and used by the facility to image and identify contraband items concealed within or on all sides of a human body. For purposes of this section, a correctional or detention facility is a facility licensed under section 241.021 and operated by a state agency or political subdivision charged with detection, enforcement, or incarceration in respect to state criminal and traffic laws.

Sec. 16. Minnesota Statutes 2018, section 144.121, is amended by adding a subdivision to read:

Subd. 9. **Exemption from examination requirements; operators of security screening systems.** (a) An employee of a correctional or detention facility who operates a security screening system and the facility in which the system is being operated are exempt from the requirements of subdivisions 5 and 6.

(b) An employee of a correctional or detention facility who operates a security screening system and the facility in which the system is being operated must meet the requirements of a variance to Minnesota Rules, parts 4732.0305 and 4732.0565, issued under Minnesota Rules, parts 4717.7000 to 4717.7050. This paragraph expires on December 31 of the year that the permanent rules adopted by the commissioner governing security screening systems are published in the State Register.

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

Sec. 17. Minnesota Statutes 2018, section 144.1506, subdivision 2, is amended to read:

Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award primary care residency expansion grants to eligible primary care residency programs to plan and implement new residency slots. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 per new residency slot for the first year, $100,000 for the second year, and $50,000 for the third year of the new residency slot. For eligible residency programs longer than three years, training grants may be awarded for the duration of the residency, not exceeding an average of $100,000 per residency slot per year.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing an accredited primary care residency program;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits residency programs;

(3) establishing new residency programs or new resident training slots;

(4) recruitment, training, and retention of new residents and faculty;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new residency slots;

(7) training site improvements, fees, equipment, and supplies required for new primary care resident training slots; and

(8) supporting clinical education in which trainees are part of a primary care team model.

Sec. 18. Minnesota Statutes 2018, section 144.225, subdivision 2, is amended to read:

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original record of birth and the certified vital record, are confidential data. At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate demographic data pertaining to the birth as public. Notwithstanding the designation of the data as confidential, it may be disclosed:

(1) to a parent or guardian of the child;

(2) to the child when the child is 16 years of age or older;

(3) under paragraph (b) ~~or~~, (e), or (f); or

(4) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

(b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible to the public become public data if 100 years have elapsed since the birth of the child who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision 1; 144.2252; and 259.89.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services, tribal health department, or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance and the MinnesotaCare program;

(2) child support enforcement purposes; and

(3) other public health purposes as determined by the commissioner of health.

(f) Tribal child support programs shall have access to birth records for child support enforcement purposes.

Sec. 19. Minnesota Statutes 2018, section 144.225, subdivision 2a, is amended to read:

Subd. 2a. **Health data associated with birth registration.** Information from which an identification of risk for disease, disability, or developmental delay in a mother or child can be made, that is collected in conjunction with birth registration or fetal death reporting, is private data as defined in section 13.02, subdivision 12. The commissioner may disclose to a tribal health department or community health board, as defined in section 145A.02, subdivision 5, health data associated with birth registration which identifies a mother or child at high risk for serious disease, disability, or developmental delay in order to assure access to appropriate health, social, or educational services. Notwithstanding the designation of the private data, the commissioner of human services shall have access to health data associated with birth registration for:

(1) purposes of administering medical assistance and the MinnesotaCare program; and

(2) for other public health purposes as determined by the commissioner of health.

Sec. 20. Minnesota Statutes 2018, section 144.225, subdivision 7, is amended to read:

Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner and payment of the required fee:

(1) to a person who has a tangible interest in the requested vital record. A person who has a tangible interest is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

(vii) the party responsible for filing the vital record;

(viii) the legal custodian, guardian or conservator, or health care agent of the subject;

(ix) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(x) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

(xii) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

(xiii) an adoption agency in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, tribal, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties;

(3) to an attorney upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state registrar or local issuance office shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to (viii), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Sec. 21. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $9.72 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 22. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

(a) The commissioner of health shall administer, or contract for the administration of, statewide tobacco cessation services to assist Minnesotans who are seeking advice or services to help them quit using tobacco products. The commissioner shall establish statewide public awareness activities to inform the public of the availability of the services and encourage the public to utilize the services because of the dangers and harm of tobacco use and dependence.

(b) Services to be provided may include but are not limited to:

(1) telephone-based coaching and counseling;

(2) referrals;

(3) written materials mailed upon request;

(4) web-based texting or e-mail services; and

(5) free Food and Drug Administration-approved tobacco cessation medications.

(c) Services provided must be consistent with evidence-based best practices in tobacco cessation services. Services provided must be coordinated with health plan company tobacco prevention and cessation services that may be available to individuals depending on their health coverage.

Sec. 23. Minnesota Statutes 2018, section 144.412, is amended to read:

144.412 PUBLIC POLICY.

The purpose of sections 144.411 to 144.417 is to protect employees and the general public from the hazards of secondhand smoke and involuntary exposure to aerosol or vapor from electronic delivery devices by eliminating smoking in public places, places of employment, public transportation, and at public meetings.

Sec. 24. Minnesota Statutes 2018, section 144.413, subdivision 1, is amended to read:

Subdivision 1. **Scope.** As used in sections 144.411 to ~~144.416~~ 144.417, the terms defined in this section have the meanings given them.

Sec. 25. Minnesota Statutes 2018, section 144.413, subdivision 4, is amended to read:

Subd. 4. **Smoking.** "Smoking" means inhaling ~~or~~, exhaling ~~smoke from~~, burning, or carrying any lighted or heated cigar, cigarette, pipe, or any other lighted ~~tobacco or plant~~ or heated product containing, made, or derived from nicotine, tobacco, marijuana, or other plant, whether natural or synthetic, that is intended for inhalation. Smoking ~~also~~ includes ~~carrying a lighted cigar, cigarette, pipe, or any other lighted tobacco or plant product intended for inhalation~~ carrying or using an activated electronic delivery device, as defined in section 609.685.

Sec. 26. Minnesota Statutes 2018, section 144.414, subdivision 2, is amended to read:

Subd. 2. **Day care premises.** ~~(a)~~ Smoking is prohibited in a day care center licensed under Minnesota Rules, parts 9503.0005 to 9503.0170, or in a family home or in a group family day care provider home licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, during its hours of operation. The proprietor of a family home or group family day care provider must disclose to parents or guardians of children cared for on the premises if the proprietor permits smoking outside of its hours of operation. Disclosure must include posting on the premises a conspicuous written notice and orally informing parents or guardians.

~~(b) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.~~

Sec. 27. Minnesota Statutes 2018, section 144.414, subdivision 3, is amended to read:

Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.

(b) Except as provided in section 246.0141, smoking by patients in a locked psychiatric unit may be allowed in a separated well-ventilated area in the unit under a policy established by the administrator of the program that allows the treating physician to approve smoking if, in the opinion of the treating physician, the benefits to be gained in obtaining patient cooperation with treatment outweigh the negative impacts of smoking.

~~(c) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.~~

Sec. 28. Minnesota Statutes 2018, section 144.416, is amended to read:

144.416 RESPONSIBILITIES OF PROPRIETORS.

(a) The proprietor or other person, firm, limited liability company, corporation, or other entity that owns, leases, manages, operates, or otherwise controls the use of a public place, public transportation, place of employment, or public meeting shall make reasonable efforts to prevent smoking in the public place, public transportation, place of employment, or public meeting by:

(1) posting appropriate signs or by any other means which may be appropriate; and

(2) asking any person who smokes in an area where smoking is prohibited to refrain from smoking and, if the person does not refrain from smoking after being asked to do so, asking the person to leave. If the person refuses to leave, the proprietor, person, or entity in charge shall handle the situation consistent with lawful methods for handling other persons acting in a disorderly manner or as a trespasser.

(b) The proprietor or other person or entity in charge of a public place, public meeting, public transportation, or place of employment must not provide smoking equipment, including

ashtrays or matches, in areas where smoking is prohibited. Nothing in this section prohibits the proprietor or other person or entity in charge from taking more stringent measures than those under sections 144.414 to 144.417 to protect individuals from secondhand smoke or from involuntary exposure to aerosol or vapor from electronic delivery devices. The proprietor or other person or entity in charge of a restaurant or bar may not serve an individual who is in violation of sections 144.411 to 144.417.

Sec. 29. Minnesota Statutes 2018, section 144.4165, is amended to read:

144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.

No person shall at any time smoke, chew, or otherwise ingest tobacco or a tobacco product, or ~~inhale or exhale vapor from~~ carry or use an activated electronic delivery device as defined in section 609.685, subdivision 1, in a public school, as defined in section 120A.05, subdivisions 9, 11, and 13, or in a charter school governed by chapter 124E, and no person under the age of 18 shall possess any of these items. This prohibition extends to all facilities, whether owned, rented, or leased, and all vehicles that a school district owns, leases, rents, contracts for, or controls. Nothing in this section shall prohibit the lighting of tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755 subdivision 12.

Sec. 30. Minnesota Statutes 2018, section 144.4167, subdivision 4, is amended to read:

Subd. 4. **Tobacco products shop.** Sections 144.414 to 144.417 do not prohibit the lighting, heating, or activation of tobacco in a tobacco products shop by a customer or potential customer for the specific purpose of sampling tobacco products. For the purposes of this subdivision, a tobacco products shop is a retail establishment ~~with~~ that has an entrance door opening directly to the outside and that derives more than 90 percent of its gross revenue from the sale of ~~loose~~ tobacco, ~~plants, or herbs and cigars, cigarettes, pipes, and other smoking devices for burning tobacco and related smoking accessories~~ tobacco-related devices, and electronic delivery devices, as defined in section 609.685, and in which the sale of other products is merely incidental. "Tobacco products shop" does not include a tobacco department or section of any individual business establishment with any type of liquor, food, or restaurant license.

Sec. 31. Minnesota Statutes 2018, section 144.417, subdivision 4, is amended to read:

Subd. 4. **Local government ordinances.** (a) Nothing in sections 144.414 to 144.417 prohibits a statutory or home rule charter city or county from enacting and enforcing more stringent measures to protect individuals from secondhand smoke or from involuntary exposure to aerosol or vapor from electronic delivery devices.

(b) Except as provided in sections 144.411 to 144.417, smoking is permitted outside of restaurants, bars, and bingo halls unless limited or prohibited by restrictions adopted in accordance with paragraph (a).

Sec. 32. Minnesota Statutes 2018, section 144.552, is amended to read:

144.552 PUBLIC INTEREST REVIEW.

(a) The following entities must submit a plan to the commissioner:

(1) a hospital seeking to increase its number of licensed beds; or

(2) an organization seeking to obtain a hospital license and notified by the commissioner under section 144.553, subdivision 1, paragraph (c), that it is subject to this section.

The plan must include information that includes an explanation of how the expansion will meet the public's interest. When submitting a plan to the commissioner, an applicant shall pay the commissioner for the commissioner's cost of reviewing and monitoring the plan, as determined by the commissioner and notwithstanding section 16A.1283. Money received by the commissioner under this section is appropriated to the commissioner for the purpose of administering this section. If the commissioner does not issue a finding within the time limit specified in paragraph (c), the commissioner must return to the applicant the entire amount the applicant paid to the commissioner. For a hospital that is seeking an exception to the moratorium under section 144.551, the plan must be submitted to the commissioner no later than August 1 of the calendar year prior to the year when the exception will be considered by the legislature.

(b) Plans submitted under this section shall include detailed information necessary for the commissioner to review the plan and reach a finding. The commissioner may request additional information from the hospital submitting a plan under this section and from others affected by the plan that the commissioner deems necessary to review the plan and make a finding. If the commissioner determines that additional information is required from the hospital submitting a plan under this section, the commissioner shall notify the hospital of the additional information required no more than 30 days after the initial submission of the plan. A hospital submitting a plan from whom the commissioner has requested additional

information shall submit the requested additional information within 14 calendar days of the commissioner's request.

(c) The commissioner shall review the plan and, within ~~90~~ 150 calendar days~~, but no more than six months if extenuating circumstances apply~~ of the date when the commissioner sends the applicant organization a notice of complete application letter, issue a finding on whether the plan is in the public interest. The commissioner shall provide a copy of the notice of complete application letter to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services policy and finance. In making the recommendation, the commissioner shall consider issues including but not limited to:

(1) whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services given the number of available beds. For the purposes of this clause, "available beds" means the number of licensed acute care beds that are immediately available for use or could be brought online within 48 hours without significant facility modifications;

(2) the financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;

(3) how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;

(4) the extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and

(5) the views of affected parties.

(d) If the plan is being submitted by an existing hospital seeking authority to construct a new hospital, the commissioner shall also consider:

(1) the ability of the applicant to maintain the applicant's current level of community benefit as defined in section 144.699, subdivision 5, at the existing facility; and

(2) the impact on the workforce at the existing facility including the applicant's plan for:

(i) transitioning current workers to the new facility;

(ii) retraining and employment security for current workers; and

(iii) addressing the impact of layoffs at the existing facility on affected workers.

(e) If the commissioner receives multiple plan submissions under this section within the same review period, the commissioner shall review the plans in the order they were received. Time periods under this section shall begin for each review once the commissioner has sent the applicant organization a notice of complete application letter. The commissioner shall provide to the chairs and ranking minority members of the house of representatives and senate committees having jurisdiction over health and human services policy and finance updates every 30 days on the progress of the review of any plan submitted under this section.

~~(e)~~ (f) Prior to making a recommendation, the commissioner shall conduct a public hearing in the affected hospital service area to take testimony from interested persons.

~~(f)~~ (g) Upon making a recommendation under paragraph (c), the commissioner shall provide a copy of the recommendation to the chairs of the house of representatives and senate committees having jurisdiction over health and human services policy and finance.

~~(g)~~ (h) If an exception to the moratorium is approved under section 144.551 after a review under this section, the commissioner shall monitor the implementation of the exception up to completion of the construction project. Thirty days after completion of the construction project, the hospital shall submit to the commissioner a report on how the construction has met the provisions of the plan originally submitted under the public interest review process or a plan submitted pursuant to section 144.551, subdivision 1, paragraph (b), clause (20).

Sec. 33. Minnesota Statutes 2018, section 144.562, subdivision 2, is amended to read:

Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total number of ~~2,000~~

days of swing bed use per year as provided in paragraph (c). Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law.

(c) An eligible hospital is allowed a total of 3,000 days of swing bed use in calendar year 2020. Beginning in calendar year 2021, and for each subsequent calendar year until calendar year 2027, the total number of days of swing bed use per year is increased by 200 swing bed use days. Beginning in calendar year 2028, an eligible hospital is allowed a total of 4,500 days of swing bed use per year.

(d) Days of swing bed use for medical care that an eligible hospital has determined are charity care shall not count toward the applicable limit in paragraph (b) or (c). For purposes of this paragraph, "charity care" means care that an eligible hospital provided for free or at a discount to persons who cannot afford to pay and for which the eligible hospital did not expect payment.

(e) Days of swing bed use for care of a person who has been denied admission to every Medicare-certified skilled nursing facility within 25 miles of the eligible hospital shall not count toward the applicable limit in paragraphs (b) and (c). Eligible hospitals must maintain documentation that they have contacted each skilled nursing facility within 25 miles to determine if any skilled nursing facility beds are available and if the skilled nursing facilities are willing to admit the patient. Skilled nursing facilities that are contacted must admit the patient or deny admission within 24 hours of being contacted by the eligible hospital. Failure to respond within 24 hours is deemed a denial of admission.

~~(c)~~ (f) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health may approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. This paragraph expires January 1, 2020.

~~(d)~~ (g) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing

bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit. This paragraph expires January 1, 2020.

~~(e)~~ (h) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year. This paragraph expires January 1, 2020.

EFFECTIVE DATE. This section is effective January 1, 2020, except that new paragraphs (d) and (e) are effective the day following final enactment.

Sec. 34. Minnesota Statutes 2018, section 144.586, is amended by adding a subdivision to read:

Subd. 3. **Care coordination implementation.** (a) This subdivision applies to hospital discharges involving a child with a high-cost medical or chronic condition who needs post-hospital continuing aftercare, including but not limited to home health care services, post-hospital extended care services, or outpatient services for follow-up or ancillary care, or is at risk of recurrent hospitalization or emergency room services due to a medical or chronic condition.

(b) In addition to complying with the discharge planning requirements in subdivision 2, the hospital must ensure that the following conditions are met and arrangements made before discharging any patient described in paragraph (a):

(1) the patient's primary care provider and either the health carrier or, if the patient is enrolled in medical assistance, the managed care organization are notified of the patient's date of anticipated discharge and provided a description of the patient's aftercare needs and a copy of the patient's discharge plan, including any necessary medical information release forms;

(2) the appropriate arrangements for home health care or post-hospital extended care services are made and the initial services as indicated on the discharge plan are scheduled; and

(3) if the patient is eligible for care coordination services through a health plan or health certified medical home, the appropriate care coordinator has connected with the patient's family.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 35. **[144.591] DISCLOSURE OF HOSPITAL CHARGES.**

(a) Each hospital, including hospitals designated as critical access hospitals, shall provide to each discharged patient within 30 calendar days of discharge an itemized description of billed charges for medical services and goods the patient received during the hospital stay. The itemized description of billed charges may include technical terms to describe the medical services and goods if the technical terms are defined on the itemized description with limited medical nomenclature. The itemized description of billed charges must not describe a billed charge using only a medical billing code, "miscellaneous charges," or "supply charges."

(b) A hospital may not bill or otherwise charge a patient for the itemized description of billed charges.

(c) A hospital must provide an itemized description by secure e-mail, via a secure online portal, or, upon request, by mail.

(d) This section does not apply to patients enrolled in Medicare, medical assistance, the MinnesotaCare program, or who receive health care coverage through an employer self-insured health plan.

EFFECTIVE DATE. This section is effective August 1, 2020.

Sec. 36. Minnesota Statutes 2018, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision; ~~and~~

(18) a representative of the Department of Education regional low-incidence facilitators~~.~~;

(19) a representative from the deaf mentor program; and

(20) a representative of the Minnesota State Academy for the Deaf from the Minnesota State Academies staff.

The commissioner must complete the initial appointments required under this subdivision by September 1, 2007, and the initial appointments under clauses (19) and (20) by September 1, 2019.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) By February 15, 2015, and by February 15 of the odd-numbered years after that date, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and data privacy on the activities of the committee that have occurred during the past two years.

(e) This subdivision expires June 30, ~~2019~~ 2025.

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

Sec. 37. Minnesota Statutes 2018, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 152.22 to 152.37; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

Sec. 38. Minnesota Statutes 2018, section 144A.43, subdivision 11, is amended to read:

Subd. 11. **Medication administration.** "Medication administration" means performing a set of tasks ~~to ensure a client takes medications, and includes~~ that include the following:

(1) checking the client's medication record;

(2) preparing the medication as necessary;

(3) administering the medication to the client;

(4) documenting the administration or reason for not administering the medication; and

(5) reporting to a registered nurse or appropriate licensed health professional any concerns about the medication, the client, or the client's refusal to take the medication.

Sec. 39. Minnesota Statutes 2018, section 144A.43, is amended by adding a subdivision to read:

Subd. 12a. **Medication reconciliation.** "Medication reconciliation" means the process of identifying the most accurate list of all medications the client is taking, including the name, dosage, frequency, and route by comparing the client record to an external list of medications obtained from the client, hospital, prescriber, or other provider.

Sec. 40. Minnesota Statutes 2018, section 144A.43, subdivision 30, is amended to read:

Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another person ~~within arm's reach to minimize the risk of injury while performing daily activities through physical intervention or cuing~~ to assist a client with an assistive task by providing cues, oversight, and minimal physical assistance.

Sec. 41. Minnesota Statutes 2018, section 144A.472, subdivision 5, is amended to read:

Subd. 5. ~~**Transfers prohibited;**~~ **Changes in ownership.** ~~Any~~ (a) A home care license issued by the commissioner may not be transferred to another party. Before acquiring ownership of or a controlling interest in a home care provider business, a prospective ~~applicant~~ owner must apply for a new ~~temporary~~ license. A change of ownership is a transfer of operational control ~~to a different business entity~~ of the home care provider business and includes:

(1) transfer of the business to a different or new corporation;

(2) in the case of a partnership, the dissolution or termination of the partnership under chapter 323A, with the business continuing by a successor partnership or other entity;

(3) relinquishment of control of the provider to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

(4) transfer of the business by a sole proprietor to another party or entity; or

(5) ~~in the case of a privately held corporation, the change in~~ transfer of ownership or control of 50 percent or more of the ~~outstanding voting stock~~ controlling interest of a home care provider business not covered by clauses (1) to (4).

(b) An employee who was employed by the previous owner of the home care provider business prior to the effective date of a change in ownership under paragraph (a), and who will be employed by the new owner in the same or a similar capacity, shall be treated as if no change in employer occurred, with respect to orientation, training, tuberculosis testing, background studies, and competency testing and training on the policies identified in subdivision 1, clause (14), and subdivision 2, if applicable.

(c) Notwithstanding paragraph (b), a new owner of a home care provider business must ensure that employees of the provider receive and complete training and testing on any provisions of policies that differ from those of the previous owner within 90 days after the date of the change in ownership.

Sec. 42. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, ~~and~~ renewal, and failure to notify.** (a) An initial applicant seeking temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(c) For the period ending June 30, 2018, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	Fee
greater than $1,500,000	$6,625
greater than $1,275,000 and no more than $1,500,000	$5,797
greater than $1,100,000 and no more than $1,275,000	$4,969
greater than $950,000 and no more than $1,100,000	$4,141
greater than $850,000 and no more than $950,000	$3,727
greater than $750,000 and no more than $850,000	$3,313
greater than $650,000 and no more than $750,000	$2,898
greater than $550,000 and no more than $650,000	$2,485
greater than $450,000 and no more than $550,000	$2,070
greater than $350,000 and no more than $450,000	$1,656
greater than $250,000 and no more than $350,000	$1,242
greater than $100,000 and no more than $250,000	$828
greater than $50,000 and no more than $100,000	$500
greater than $25,000 and no more than $50,000	$400
no more than $25,000	$200

(d) For the period between July 1, 2018, and June 30, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner in an amount that is ten percent higher than the applicable fee in paragraph (c). A home care provider's fee shall be based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted.

(e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	Fee
greater than $1,500,000	$7,651
greater than $1,275,000 and no more than $1,500,000	$6,695
greater than $1,100,000 and no more than $1,275,000	$5,739
greater than $950,000 and no more than $1,100,000	$4,783

greater than $850,000 and no more than $950,000	$4,304
greater than $750,000 and no more than $850,000	$3,826
greater than $650,000 and no more than $750,000	$3,347
greater than $550,000 and no more than $650,000	$2,870
greater than $450,000 and no more than $550,000	$2,391
greater than $350,000 and no more than $450,000	$1,913
greater than $250,000 and no more than $350,000	$1,434
greater than $100,000 and no more than $250,000	$957
greater than $50,000 and no more than $100,000	$577
greater than $25,000 and no more than $50,000	$462
no more than $25,000	$231

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

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

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

(i) The fine for failure to comply with the notification requirements of section 144A.473, subdivision 2, paragraph (c), is $1,000.

(j) Fees and penalties collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if received before July 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

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

Sec. 43. Minnesota Statutes 2018, section 144A.473, is amended to read:

144A.473 ISSUANCE OF TEMPORARY LICENSE AND LICENSE RENEWAL.

Subdivision 1. **Temporary license and renewal of license.** (a) The department shall review each application to determine the applicant's knowledge of and compliance with Minnesota home care regulations. Before granting a temporary license or renewing a license, the commissioner may further evaluate the applicant or licensee by requesting additional

information or documentation or by conducting an on-site survey of the applicant to determine compliance with sections 144A.43 to 144A.482.

(b) Within 14 calendar days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete.

(c) Within 90 days after receiving a complete application, the commissioner shall issue a temporary license, renew the license, or deny the license.

(d) The commissioner shall issue a license that contains the home care provider's name, address, license level, expiration date of the license, and unique license number. All licenses, except for temporary licenses issued under subdivision 2, are valid for up to one year from the date of issuance.

Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner shall issue a temporary license for either the basic or comprehensive home care level. A temporary license is effective for up to one year from the date of issuance, except that a temporary license may be extended according to subdivision 3. Temporary licensees must comply with sections 144A.43 to 144A.482.

(b) During the temporary license ~~year~~ period, the commissioner shall survey the temporary licensee within 90 calendar days after the commissioner is notified or has evidence that the temporary licensee is providing home care services.

(c) Within five days of beginning the provision of services, the temporary licensee must notify the commissioner that it is serving clients. The notification to the commissioner may be mailed or e-mailed to the commissioner at the address provided by the commissioner. If the temporary licensee does not provide home care services during the temporary license ~~year~~ period, then the temporary license expires at the end of the ~~year~~ period and the applicant must reapply for a temporary home care license.

(d) A temporary licensee may request a change in the level of licensure prior to being surveyed and granted a license by notifying the commissioner in writing and providing additional documentation or materials required to update or complete the changed temporary license application. The applicant must pay the difference between the application fees when changing from the basic level to the comprehensive level of licensure. No refund will be made if the provider chooses to change the license application to the basic level.

(e) If the temporary licensee notifies the commissioner that the licensee has clients within 45 days prior to the temporary license expiration, the commissioner may extend the temporary license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial compliance with the survey, the commissioner shall issue either a basic or comprehensive home care license. If the temporary licensee is not in substantial compliance with the survey, the commissioner shall either: (1) not issue a ~~basic or comprehensive~~ license and ~~there will be no contested hearing right under chapter 14.~~ terminate the temporary license; or (2) extend the temporary license for a period not to exceed 90 days and apply conditions, as permitted under section 144A.475, subdivision 2, to the extension of a temporary license. If the temporary licensee is not in substantial compliance with the survey within the time period of the extension, or if the temporary licensee does not satisfy the license conditions, the commissioner may deny the license.

(b) If the temporary licensee whose basic or comprehensive license has been denied or extended with conditions disagrees with the conclusions of the commissioner, then the temporary licensee may request a reconsideration by the commissioner or commissioner's designee. The reconsideration request process must be conducted internally by the commissioner or commissioner's designee, and chapter 14 does not apply.

(c) The temporary licensee requesting reconsideration must make the request in writing and must list and describe the reasons why the temporary licensee disagrees with the decision to deny the basic or comprehensive home care license or the decision to extend the temporary license with conditions.

(d) The reconsideration request and supporting documentation must be received by the commissioner within 15 calendar days after the date the temporary licensee receives the correction order.

(e) A temporary licensee whose license is denied, is permitted to continue operating as a home care provider during the period of time when:

(1) a reconsideration request is in process;

(2) an extension of a temporary license is being negotiated;

(3) the placement of conditions on a temporary license is being negotiated; or

(4) a transfer of home care clients from the temporary licensee to a new home care provider is in process.

(f) A temporary licensee whose license is denied must comply with the requirements for notification and transfer of clients in section 144A.475, subdivision 5.

Sec. 44. Minnesota Statutes 2018, section 144A.474, subdivision 2, is amended to read:

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

(b) "Change in ownership survey" means a full survey of a new licensee due to a change in ownership. Change in ownership surveys must be completed within six months after the department's issuance of a new license due to a change in ownership.

(c) "Core survey" means periodic inspection of home care providers to determine ongoing compliance with the home care requirements, focusing on the essential health and safety requirements. Core surveys are available to licensed home care providers who have been licensed for three years and surveyed at least once in the past three years with the latest survey having no widespread violations beyond Level 1 as provided in subdivision 11. Providers must also not have had any substantiated licensing complaints, substantiated complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors Act, or an enforcement action as authorized in section 144A.475 in the past three years.

(1) The core survey for basic home care providers must review compliance in the following areas:

(i) reporting of maltreatment;

(ii) orientation to and implementation of the home care bill of rights;

(iii) statement of home care services;

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

(v) client review and monitoring;

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

(vii) client complaint and investigative process;

(viii) competency of unlicensed personnel; and

(ix) infection control.

(2) For comprehensive home care providers, the core survey must include everything in the basic core survey plus these areas:

(i) delegation to unlicensed personnel;

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

(iii) medication, treatment, and therapy management.

~~(c)~~ (d) "Full survey" means the periodic inspection of home care providers to determine ongoing compliance with the home care requirements that cover the core survey areas and all the legal requirements for home care providers. A full survey is conducted for all temporary licensees ~~and~~, for licensees that receive licenses due to an approved change in ownership, for providers who do not meet the requirements needed for a core survey, and when a surveyor identifies unacceptable client health or safety risks during a core survey. A full survey must include all the tasks identified as part of the core survey and any additional review deemed necessary by the department, including additional observation, interviewing, or records review of additional clients and staff.

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

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

Sec. 45. Minnesota Statutes 2018, section 144A.475, subdivision 1, is amended to read:

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider:

(1) is in violation of, or during the term of the license has violated, any of the requirements in sections 144A.471 to 144A.482;

(2) permits, aids, or abets the commission of any illegal act in the provision of home care;

(3) performs any act detrimental to the health, safety, and welfare of a client;

(4) obtains the license by fraud or misrepresentation;

(5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

(6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the home care provider's clients;

(8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department;

(9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter;

(10) refuses to initiate a background study under section 144.057 or 245A.04;

(11) fails to timely pay any fines assessed by the department;

(12) violates any local, city, or township ordinance relating to home care services;

(13) has repeated incidents of personnel performing services beyond their competency level; or

(14) has operated beyond the scope of the home care provider's license level.

(b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider.

Sec. 46. Minnesota Statutes 2018, section 144A.475, subdivision 2, is amended to read:

Subd. 2. **Terms to suspension or conditional license.** (a) A suspension or conditional license designation may include terms that must be completed or met before a suspension or conditional license designation is lifted. A conditional license designation may include restrictions or conditions that are imposed on the provider. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the home care provider's practices and submit reports to the commissioner at the cost of the home care provider;

(2) requiring supervision of the home care provider or staff practices at the cost of the home care provider by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the home care provider or employees to obtain training at the cost of the home care provider;

(4) requiring the home care provider to submit reports to the commissioner;

(5) prohibiting the home care provider from taking any new clients for a period of time; or

(6) any other action reasonably required to accomplish the purpose of this subdivision and section 144A.45, subdivision 2.

(b) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 47. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

Subd. 5. **Plan required.** (a) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the home care provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the home care provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information:

(1) a list of all clients, including full names and all contact information on file;

(2) a list of each client's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each client;

(4) the payor sources for each client, including payor source identification numbers; and

(5) for each client, a copy of the client's service plan, and a list of the types of services being provided.

(b) The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care provider shall cooperate with the commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the home care provider must notify and disclose to each of the home

care provider's clients, or the client's representative or emergency contact persons, that the commissioner is taking action against the home care provider's license by providing a copy of the revocation or suspension notice issued by the commissioner.

(c) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 48. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before the commissioner issues a temporary license, issues a license as a result of an approved change in ownership, or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the

other home care provider's failure to substantially comply with sections 144A.43 to 144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

Sec. 49. Minnesota Statutes 2018, section 144A.479, subdivision 7, is amended to read:

Subd. 7. **Employee records.** The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information:

(1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules;

(2) records of orientation, required annual training and infection control training, and competency evaluations;

(3) current job description, including qualifications, responsibilities, and identification of staff providing supervision;

(4) documentation of annual performance reviews which identify areas of improvement needed and training needs;

(5) for individuals providing home care services, verification that ~~required~~ any health screenings required by infection control programs established under section 144A.4798 have taken place and the dates of those screenings; and

(6) documentation of the background study as required under section 144.057.

Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.

Sec. 50. Minnesota Statutes 2018, section 144A.479, is amended by adding a subdivision to read:

Subd. 8. **Labor market reporting.** A home care provider shall comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a.

Sec. 51. Minnesota Statutes 2018, section 144A.4791, subdivision 1, is amended to read:

Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care provider shall provide the client or the client's representative a written notice of the rights under section 144A.44 before the ~~initiation of~~ date that services are first provided to that client. The provider shall make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

(b) In addition to the text of the home care bill of rights in section 144A.44, subdivision 1, the notice shall also contain the following statement describing how to file a complaint with these offices.

"If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

The statement should include the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or complaints may be directed. It must also include a statement that the home care provider will not retaliate because of a complaint.

(c) The home care provider shall obtain written acknowledgment of the client's receipt of the home care bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of receipt shall be retained in the client's record.

Sec. 52. Minnesota Statutes 2018, section 144A.4791, subdivision 3, is amended to read:

Subd. 3. **Statement of home care services.** Prior to the ~~initiation of~~ date that services are first provided to the client, a home care provider must provide to the client or the client's representative a written statement which identifies if the provider has a basic or comprehensive home care license, the services the provider is authorized to provide, and which services the provider cannot provide under the scope of the provider's license. The home care provider shall obtain written acknowledgment from the clients that the provider

has provided the statement or must document why the provider could not obtain the acknowledgment.

Sec. 53. Minnesota Statutes 2018, section 144A.4791, subdivision 6, is amended to read:

Subd. 6. **Initiation of services.** When a provider ~~initiates~~ provides home care services ~~and~~ to a client before the individualized review or assessment by a licensed health professional or registered nurse as required in subdivisions 7 and 8 ~~has not been~~ is completed, the ~~provider~~ licensed health professional or registered nurse must complete a temporary plan ~~and agreement~~ with the client ~~for services~~ and orient staff assigned to deliver services as identified in the temporary plan.

Sec. 54. Minnesota Statutes 2018, section 144A.4791, subdivision 7, is amended to read:

Subd. 7. **Basic individualized client review and monitoring.** (a) When services being provided are basic home care services, an individualized initial review of the client's needs and preferences must be conducted at the client's residence with the client or client's representative. This initial review must be completed within 30 days after the ~~initiation of the~~ date that home care services are first provided.

(b) Client monitoring and review must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the date of the last review. The monitoring and review may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Sec. 55. Minnesota Statutes 2018, section 144A.4791, subdivision 8, is amended to read:

Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after ~~initiation of~~ the date that home care services are first provided.

(b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after ~~initiation of~~ the date that home care services are first provided.

(c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence

or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Sec. 56. Minnesota Statutes 2018, section 144A.4791, subdivision 9, is amended to read:

Subd. 9. **Service plan, implementation, and revisions to service plan.** (a) No later than 14 days after the ~~initiation of~~ date that home care services are first provided, a home care provider shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

(c) The home care provider must implement and provide all services required by the current service plan.

(d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.

(e) Staff providing home care services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;

(2) the identification of the staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring reviews or assessments of the client;

(4) ~~the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and~~ the schedule and methods of monitoring staff providing home care services; and

(5) a contingency plan that includes:

(i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided;

(ii) information and a method for a client or client's representative to contact the home care provider;

(iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition~~, including identification of and information as to who has authority to sign for the client in an emergency~~; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Sec. 57. Minnesota Statutes 2018, section 144A.4792, subdivision 1, is amended to read:

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

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

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

Sec. 58. Minnesota Statutes 2018, section 144A.4792, subdivision 2, is amended to read:

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

(b) The assessment must:

(1) identify interventions needed in management of medications to prevent diversion of medication by the client or others who may have access to the medications; and

(2) provide instructions to the client or client's representative on interventions to manage the client's medications and prevent diversion of medications.

"Diversion of medications" means the misuse, theft, or illegal or improper disposition of medications.

Sec. 59. Minnesota Statutes 2018, section 144A.4792, subdivision 5, is amended to read:

Subd. 5. **Individualized medication management plan.** (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following:

(1) a statement describing the medication management services that will be provided;

(2) a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;

(3) documentation of specific client instructions relating to the administration of medications;

(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(5) identification of medication management tasks that may be delegated to unlicensed personnel;

(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and

(7) any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

Sec. 60. Minnesota Statutes 2018, section 144A.4792, subdivision 10, is amended to read:

Subd. 10. **Medication management for clients who will be away from home.** (a) A home care provider who is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's individualized medication management plan. The policy and procedures must state that:

(1) for planned time away, the medications must be obtained from the pharmacy or set up by ~~the registered~~ a licensed nurse according to appropriate state and federal laws and nursing standards of practice;

(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed ~~120 hours~~ seven calendar days;

(3) the client or client's representative must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances;

(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and

(5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.

(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:

(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients; and

(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address:

(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;

(ii) how the container or containers must be labeled;

(iii) the written information about the medications to be given to the client or client's representative;

(iv) how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person who gave the medications to the client, the number of medications that were given to the client, and other required information;

(v) how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative; ~~and~~

(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel~~.~~; and

(vii) how the unlicensed staff must document in the client's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication.

Sec. 61. Minnesota Statutes 2018, section 144A.4793, subdivision 6, is amended to read:

Subd. 6. **Treatment and therapy orders ~~or prescriptions.~~** There must be an up-to-date written or electronically recorded order ~~or prescription~~ from an authorized prescriber for all treatments and therapies. The order must contain the name of the client, a description of the treatment or therapy to be provided, and the frequency, duration, and other information

needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

Sec. 62. Minnesota Statutes 2018, section 144A.4796, subdivision 2, is amended to read:

Subd. 2. **Content.** (a) The orientation must contain the following topics:

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

(2) introduction and review of all the provider's policies and procedures related to the provision of home care services by the individual staff person;

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

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

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

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

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

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

(b) In addition to the topics listed in paragraph (a), orientation may also contain training on providing services to clients with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research-based, may include online training, and must include training on one or more of the following topics:

(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;

(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or

(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

Sec. 63. Minnesota Statutes 2018, section 144A.4797, subdivision 3, is amended to read:

Subd. 3. **Supervision of staff providing delegated nursing or therapy home care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the date on which the individual begins working for the home care provider and first performs delegated tasks for clients and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

Sec. 64. Minnesota Statutes 2018, section 144A.4798, is amended to read:

144A.4798 ~~EMPLOYEE HEALTH STATUS~~ DISEASE PREVENTION AND INFECTION CONTROL.

Subdivision 1. **Tuberculosis (TB) ~~prevention and~~ infection control.** (a) A home care provider must establish and maintain a ~~TB prevention and~~ comprehensive tuberculosis infection control program ~~based on~~ according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. ~~Components of a TB prevention and control program include screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection, and developing and implementing a written TB infection control plan. The commissioner shall make the most recent CDC standards available to home care providers on the department's website.~~ This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.

(b) The home care provider must maintain written evidence of compliance with this subdivision.

Subd. 2. **Communicable diseases.** A home care provider must follow current ~~federal or state guidelines~~ state requirements for prevention, control, and reporting of ~~human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other~~ communicable diseases as defined in Minnesota Rules, ~~part~~ parts 4605.7040, 4605.7044, 4605.7050, 4605.7075, 4605.7080, and 4605.7090.

Subd. 3. **Infection control program.** A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control.

Sec. 65. Minnesota Statutes 2018, section 144A.4799, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care and assisted living program advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be ~~either~~ persons who are currently receiving home care services ~~or~~, persons who have received home care services within five years of the application date, persons who have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; and

(4) one member representing the Office of Ombudsman for Long-Term Care.

Sec. 66. Minnesota Statutes 2018, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care;

(4) training standards;

(5) identifying emerging issues and opportunities in ~~the~~ home care ~~field, including~~ and assisted living;

(6) identifying the use of technology in home and telehealth capabilities;

~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually review the balance of the account in the state government special revenue fund described in section 144A.474, subdivision 11, paragraph (i), and make annual recommendations by January 15 directly to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding appropriations to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i).

Sec. 67. Minnesota Statutes 2018, section 144A.484, subdivision 1, is amended to read:

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 this chapter as required under Laws 2013, chapter 108, article 8, section 60, and article 11, section 31. During this period, the commissioner shall provide technical assistance to achieve and maintain compliance with applicable law or rules governing the provision of home and community-based services, including complying with the service recipient rights notice in subdivision 4, clause (4). If during the survey, the commissioner finds that the licensee has failed to achieve compliance with an applicable law or rule under chapter 245D 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 survey report with recommendations for achieving and maintaining compliance.~~

~~(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 support services identified under section 245D.03, subdivision 1, paragraph (b). The designation allows the license holder to provide basic support 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~~ 144A.4799.

Sec. 68. Minnesota Statutes 2018, section 145.908, subdivision 1, is amended to read:

Subdivision 1. **Grant program established.** Within the limits of ~~federal funds~~ available ~~specifically~~ appropriations for this purpose, the commissioner of health shall establish a grant program to provide culturally competent programs to screen and treat pregnant women and women who have given birth in the preceding 12 months for pre- and postpartum mood and anxiety disorders. Organizations may use grant funds to establish new screening or treatment programs, or expand or maintain existing screening or treatment programs. In establishing the grant program, the commissioner shall prioritize expanding or enhancing screening for pre- and postpartum mood and anxiety disorders in primary care settings. The commissioner shall determine the types of organizations eligible for grants.

Sec. 69. Minnesota Statutes 2018, section 145.928, subdivision 1, is amended to read:

Subdivision 1. **Goal; establishment.** It is the goal of the state~~, by 2010,~~ to decrease ~~by 50 percent~~ the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, access to and utilization of high-quality prenatal care, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Sec. 70. Minnesota Statutes 2018, section 145.928, subdivision 7, is amended to read:

Subd. 7. **Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates.** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or ~~both~~ more of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates; ~~or~~

(2) decreasing racial and ethnic disparities in access to and utilization of high-quality prenatal care; or

~~(2)~~ (3) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or ~~both~~ more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact ~~both~~ two or more priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Sec. 71. Minnesota Statutes 2018, section 145.986, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** The purpose of the statewide health improvement program is to:

(1) address the ~~top three~~ leading preventable causes of illness and death~~: tobacco use and exposure, poor diet, and lack of regular physical activity~~ such as tobacco use or exposure, poor diet, and lack of regular physical activity, and other issues as determined by the commissioner through the statewide health assessment;

(2) promote the development, availability, and use of evidence-based, community level, comprehensive strategies to create healthy communities; and

(3) measure the impact of the evidence-based, community health improvement practices which over time work to contain health care costs and reduce chronic diseases.

Sec. 72. Minnesota Statutes 2018, section 145.986, subdivision 1a, is amended to read:

Subd. 1a. **Grants to local communities.** (a) ~~Beginning July 1, 2009,~~ The commissioner of health shall award competitive grants to community health boards and tribal governments to convene, coordinate, and implement ~~evidence-based~~ proven-effective strategies ~~targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco~~, promising practice strategies, or theory-based strategies that can be evaluated using experimental or quasi-experimental design. Grants shall be awarded to all community health boards and tribal governments whose proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 1 and other requirements of this section. In each grant cycle, the commissioner may award up to 100 percent of tribal grants and up to 25 percent of the grants awarded to community health boards to theory-based strategies that are culturally or ethnically focused.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, work site, and health care settings;

(5) be focused on policy, systems, and environmental changes that support healthy behaviors; and

(6) address the health disparities and inequities that exist in the grantee's community.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

(f) Grant recipients shall report their activities and their progress toward the outcomes established under subdivision 2 to the commissioner in a format and at a time specified by the commissioner.

(g) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 2. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

(h) ~~Beginning November 1, 2015, the commissioner shall offer grant recipients the option of using a grant awarded under this subdivision to implement health improvement strategies that improve the health status, delay the expression of dementia, or slow the progression of dementia, for a targeted population at risk for dementia and shall award at least two of the grants awarded on November 1, 2015, for these purposes. The grants must meet all other requirements of this section. The commissioner shall coordinate grant planning activities with the commissioner of human services, the Minnesota Board on Aging, and community-based organizations with a focus on dementia. Each grant must include selected outcomes and evaluation measures related to the incidence or progression of dementia among the targeted population using the procedure described in subdivision 2.~~ For purposes of this subdivision, "proven-effective" means a strategy or practice that offers a high level of research on effectiveness for at least one outcome of interest; "promising practice" means a practice or activity that is supported by research demonstrating effectiveness for at least one outcome of interest; and "theory-based" means a strategy or activity that has no research on effectiveness but has a well-constructed logical model or theory of change.

~~(i) Beginning July 1, 2017, the commissioner shall offer grant recipients the option of using a grant awarded under this subdivision to confront the opioid addiction and overdose epidemic, and shall award at least two of the grants awarded on or after July 1, 2017, for these purposes. The grants awarded under this paragraph must meet all other requirements of this section. The commissioner shall coordinate grant planning activities with the commissioner of human services. Each grant shall include selected outcomes and evaluation measures related to addressing the opioid epidemic.~~

Sec. 73. Minnesota Statutes 2018, section 145.986, subdivision 4, is amended to read:

Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program grants funded under this section. The evaluation must use the most appropriate experimental or quasi-experimental design suitable for the grant activity or project. Grant

recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation, including information on any impact on the health indicators listed in section 62U.10, subdivision 6, within the geographic area or among the population targeted.

(b) Grant recipients will collect, monitor, and submit to the Department of Health baseline and annual data and provide information to improve the quality and impact of community health improvement strategies.

(c) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in designing and implementing evaluation systems. The commissioner shall consult with the commissioner of management and budget to ensure that the evaluation process is using experimental or quasi-experimental design.

(d) Contracts awarded under paragraph (c) may be used to:

(1) develop grantee monitoring and reporting systems to track grantee progress, including aggregated and disaggregated data;

(2) manage, analyze, and report program evaluation data results; and

(3) utilize innovative support tools to analyze and predict the impact of prevention strategies on health outcomes and state health care costs over time.

(e) For purposes of this subdivision, "experimental design" means a method of evaluating the impact of a strategy that uses random assignment to establish statistically similar groups, so that any difference in outcomes found at the end of the evaluation can be attributed to the strategy being evaluated; and "quasi-experimental design" means a method of evaluating the impact of a strategy that uses an approach other than random assignment to establish statistically similar groups, so that any difference in outcomes found at the end of the evaluation can be attributed to the strategy being evaluated.

Sec. 74. Minnesota Statutes 2018, section 145.986, subdivision 5, is amended to read:

Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. The report must include information on each grant recipient, including the activities that were conducted by the grantee using grant funds, the grantee's progress toward achieving the measurable outcomes established under subdivision 2, and the data provided to the commissioner by the grantee to measure these outcomes for grant activities. The commissioner shall provide information on grants in which a corrective action plan was required under subdivision 1a,

the types of plan action, and the progress that has been made toward meeting the measurable outcomes. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. ~~In the report due on January 15, 2014,~~ In the reports due beginning January 15, 2020, the commissioner shall include a description of the contracts awarded under subdivision 4, paragraph (c), and the monitoring and evaluation systems that were designed and implemented under these contracts.

Sec. 75. Minnesota Statutes 2018, section 145.986, subdivision 6, is amended to read:

Subd. 6. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs ~~that work to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco~~, or replace discontinued state or federal funds ~~previously used to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco~~. Funds must not be used to supplant current state or local funding to community health boards or tribal governments ~~used to reduce the percentage of Minnesotans who are obese or overweight or to reduce tobacco use~~.

Sec. 76. **[151.72] SALE OF CERTAIN CANNABINOID PRODUCTS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Hemp" has the meaning given to "industrial hemp" in section 18K.02, subdivision 3.

(c) "Labeling" means all labels and other written, printed, or graphic matter that are:

(1) affixed to the immediate container in which a product regulated under this section is sold; or

(2) provided, in any manner, with the immediate container, including but not limited to outer containers, wrappers, package inserts, brochures, or pamphlets.

Subd. 2. **Scope.** (a) This section applies to the sale of any product that contains nonintoxicating cannabinoids extracted from hemp other than food that is intended for human or animal consumption by any route of administration.

(b) This section does not apply to any product dispensed by a registered medical cannabis manufacturer pursuant to sections 152.22 to 152.37.

Subd. 3. **Sale of cannabinoids derived from hemp.** Notwithstanding any other section of this chapter, a product containing nonintoxicating cannabinoids may be sold for human or animal consumption if all of the requirements of this section are met.

Subd. 4. **Testing requirements.** (a) A manufacturer of a product regulated under this section must submit representative samples of the product to an independent, accredited laboratory in order to certify that the product complies with the standards adopted by the board. Testing must be consistent with generally accepted industry standards for herbal and botanical substances, and at a minimum, the testing must confirm that the product:

(1) contains the amount or percentage of cannabinoids that is stated on the label of the product;

(2) does not contain more than trace amounts of any pesticides, fertilizers, or heavy metals; and

(3) does not contain a delta-9 tetrahydrocannabinol concentration that exceeds the concentration permitted for industrial hemp as defined in section 18K.02, subdivision 3.

(b) Upon the request of the board, the manufacturer of the product must provide the board with the results of the testing required in this section.

Subd. 5. **Labeling requirements.** (a) A product regulated under this section must bear a label that contains, at a minimum:

(1) the name, location, contact phone number, and website of the manufacturer of the product;

(2) the name and address of the independent, accredited laboratory used by the manufacturer to test the product;

(3) an accurate statement of the amount or percentage of cannabinoids found in each unit of the product meant to be consumed; and

(4) a statement stating that this product does not claim to diagnose, treat, cure, or prevent any disease and has not been evaluated or approved by the United States Food and Drug Administration (FDA) unless the product has been so approved.

(b) The information required to be on the label must be prominently and conspicuously placed and in terms that can be easily read and understood by the consumer.

(c) The label must not contain any claim that the product may be used or is effective for the prevention, treatment, or cure of a disease or that it may be used to alter the structure or function of human or animal bodies, unless the claim has been approved by the FDA.

Subd. 6. **Enforcement.** (a) A product sold under this section shall be considered an adulterated drug if:

(1) it consists, in whole or in part, of any filthy, putrid, or decomposed substance;

(2) it has been produced, prepared, packed, or held under unsanitary conditions where it may have been rendered injurious to health, or where it may have been contaminated with filth;

(3) its container is composed, in whole or in part, of any poisonous or deleterious substance that may render the contents injurious to health;

(4) it contains any color additives or excipients that have been found by the FDA to be unsafe for human or animal consumption; or

(5) it contains an amount or percentage of cannabinoids that is different than the amount or percentage stated on the label.

(b) A product sold under this section shall be considered a misbranded drug if the product's labeling is false or misleading in any manner or in violation of the requirements of this section.

(c) The board's authority to issue cease and desist orders under section 151.06; to embargo adulterated and misbranded drugs under section 151.38; and to seek injunctive relief under section 214.11, extends to any violation of this section.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to any product sold in Minnesota on or after that date.

Sec. 77. Minnesota Statutes 2018, section 152.01, subdivision 9, is amended to read:

Subd. 9. **Marijuana.** "Marijuana" means all parts of the plant of any species of the genus Cannabis, including all agronomical varieties, whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin, but shall not include the mature stalks of such plant, fiber from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks, except the resin extracted therefrom, fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination. Marijuana does not include hemp as defined in section 152.22, subdivision 5a.

Sec. 78. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to read:

Subd. 5a. **Hemp.** "Hemp" has the meaning given to industrial hemp in section 18K.02, subdivision 3.

Sec. 79. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to read:

Subd. 5b. **Hemp grower.** "Hemp grower" means a person licensed by the commissioner of agriculture under chapter 18K to grow hemp for commercial purposes.

Sec. 80. Minnesota Statutes 2018, section 152.22, subdivision 6, is amended to read:

Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, and is delivered in the form of:

(1) liquid, including, but not limited to, oil;

(2) pill;

(3) vaporized delivery method with use of liquid or oil but which does not require the use of dried leaves or plant form; or

(4) any other method, excluding smoking, approved by the commissioner.

(b) This definition includes any part of the genus cannabis plant prior to being processed into a form allowed under paragraph (a), that is possessed by a person while that person is engaged in employment duties necessary to carry out a requirement under sections 152.22 to 152.37 for a registered manufacturer or a laboratory under contract with a registered manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp grower as permitted under section 152.29, subdivision 1, paragraph (b).

Sec. 81. Minnesota Statutes 2018, section 152.22, subdivision 11, is amended to read:

Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means a person who:

(1) is at least ~~21~~ 18 years old;

(2) does not have a conviction for a disqualifying felony offense;

(3) has been approved by the commissioner to assist a patient who has been identified by a health care practitioner as developmentally or physically disabled and therefore ~~unable~~

~~to self-administer medication~~ requires assistance in administering medical cannabis or ~~acquire~~ obtaining medical cannabis from a distribution facility due to the disability; and

(4) is authorized by the commissioner to assist the patient with the use of medical cannabis.

Sec. 82. Minnesota Statutes 2018, section 152.22, subdivision 13, is amended to read:

Subd. 13. **Registry verification.** "Registry verification" means the verification provided by the commissioner that a patient is enrolled in the registry program and that includes the patient's name, registry number, ~~and qualifying medical condition~~ and, if applicable, the name of the patient's registered designated caregiver or parent ~~or~~, legal guardian, or spouse.

Sec. 83. Minnesota Statutes 2018, section 152.25, subdivision 1, is amended to read:

Subdivision 1. **Medical cannabis manufacturer registration.** (a) The commissioner shall register two in-state manufacturers for the production of all medical cannabis within the state. A registration agreement between the commissioner and a manufacturer is nontransferable. The commissioner shall register new manufacturers or reregister the existing manufacturers by December 1 every two years, using the factors described in this subdivision. The commissioner shall accept applications after December 1, 2014, if one of the manufacturers registered before December 1, 2014, ceases to be registered as a manufacturer. The commissioner's determination that no manufacturer exists to fulfill the duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County District Court. Data submitted during the application process are private data on individuals or nonpublic data as defined in section 13.02 until the manufacturer is registered under this section. Data on a manufacturer that is registered are public data, unless the data are trade secret or security information under section 13.37.

(b) As a condition for registration, a manufacturer must agree to:

(1) begin supplying medical cannabis to patients by July 1, 2015; and

(2) comply with all requirements under sections 152.22 to 152.37.

(c) The commissioner shall consider the following factors when determining which manufacturer to register:

(1) the technical expertise of the manufacturer in cultivating medical cannabis and converting the medical cannabis into an acceptable delivery method under section 152.22, subdivision 6;

(2) the qualifications of the manufacturer's employees;

(3) the long-term financial stability of the manufacturer;

(4) the ability to provide appropriate security measures on the premises of the manufacturer;

(5) whether the manufacturer has demonstrated an ability to meet the medical cannabis production needs required by sections 152.22 to 152.37; and

(6) the manufacturer's projection and ongoing assessment of fees on patients with a qualifying medical condition.

(d) If an officer, director, or controlling person of the manufacturer pleads or is found guilty of intentionally diverting medical cannabis to a person other than allowed by law under section 152.33, subdivision 1, the commissioner may decide not to renew the registration of the manufacturer, provided the violation occurred while the person was an officer, director, or controlling person of the manufacturer.

(e) The commissioner shall require each medical cannabis manufacturer to contract with an independent laboratory to test medical cannabis produced by the manufacturer. The commissioner shall approve the laboratory chosen by each manufacturer and require that the laboratory report testing results to the manufacturer in a manner determined by the commissioner.

Sec. 84. Minnesota Statutes 2018, section 152.25, subdivision 1a, is amended to read:

Subd. 1a. **Revocation~~,~~ or nonrenewal~~, or denial of consent to transfer~~ of a medical cannabis manufacturer registration.** If the commissioner intends to revoke~~,~~ or not renew~~, or deny consent to transfer~~ a registration issued under this section, the commissioner must first notify in writing the manufacturer against whom the action is to be taken and provide the manufacturer with an opportunity to request a hearing under the contested case provisions of chapter 14. If the manufacturer does not request a hearing by notifying the commissioner in writing within 20 days after receipt of the notice of proposed action, the commissioner may proceed with the action without a hearing. For revocations, the registration of a manufacturer is considered revoked on the date specified in the commissioner's written notice of revocation.

Sec. 85. Minnesota Statutes 2018, section 152.25, subdivision 1c, is amended to read:

Subd. 1c. **Notice to patients.** Upon the revocation or nonrenewal of a manufacturer's registration under subdivision 1a or implementation of an enforcement action under

subdivision 1b that may affect the ability of a registered patient, registered designated caregiver, or a registered patient's parent ~~or~~, legal guardian, or spouse to obtain medical cannabis from the manufacturer subject to the enforcement action, the commissioner shall notify in writing each registered patient and the patient's registered designated caregiver or registered patient's parent ~~or~~, legal guardian, or spouse about the outcome of the proceeding and information regarding alternative registered manufacturers. This notice must be provided two or more business days prior to the effective date of the revocation, nonrenewal, or other enforcement action.

Sec. 86. Minnesota Statutes 2018, section 152.25, subdivision 4, is amended to read:

Subd. 4. **Reports.** (a) The commissioner shall provide regular updates to the task force on medical cannabis therapeutic research and to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, public safety, judiciary, and civil law regarding: (1) any changes in federal law or regulatory restrictions regarding the use of medical cannabis or hemp; and (2) the market demand and supply in this state for products made from hemp that can be used for medicinal purposes.

(b) The commissioner may submit medical research based on the data collected under sections 152.22 to 152.37 to any federal agency with regulatory or enforcement authority over medical cannabis to demonstrate the effectiveness of medical cannabis for treating a qualifying medical condition.

Sec. 87. Minnesota Statutes 2018, section 152.27, subdivision 2, is amended to read:

Subd. 2. **Commissioner duties.** (a) The commissioner shall:

(1) give notice of the program to health care practitioners in the state who are eligible to serve as health care practitioners and explain the purposes and requirements of the program;

(2) allow each health care practitioner who meets or agrees to meet the program's requirements and who requests to participate, to be included in the registry program to collect data for the patient registry;

(3) provide explanatory information and assistance to each health care practitioner in understanding the nature of therapeutic use of medical cannabis within program requirements;

(4) create and provide a certification to be used by a health care practitioner for the practitioner to certify whether a patient has been diagnosed with a qualifying medical condition and include in the certification an option for the practitioner to certify whether

the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability, the patient ~~is unable to self-administer medication~~ requires assistance in administering medical cannabis or ~~acquire~~ obtaining medical cannabis from a distribution facility;

(5) supervise the participation of the health care practitioner in conducting patient treatment and health records reporting in a manner that ensures stringent security and record-keeping requirements and that prevents the unauthorized release of private data on individuals as defined by section 13.02;

(6) develop safety criteria for patients with a qualifying medical condition as a requirement of the patient's participation in the program, to prevent the patient from undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice on the part of the patient; and

(7) conduct research and studies based on data from health records submitted to the registry program and submit reports on intermediate or final research results to the legislature and major scientific journals. The commissioner may contract with a third party to complete the requirements of this clause. Any reports submitted must comply with section 152.28, subdivision 2.

(b) The commissioner may add a delivery method under section 152.22, subdivision 6, or add or modify a qualifying medical condition under section 152.22, subdivision 14, upon a petition from a member of the public or the task force on medical cannabis therapeutic research or as directed by law. The commissioner shall evaluate all petitions to add a qualifying medical condition or modify an existing qualifying medical condition submitted by the task force on medical cannabis therapeutic research or as directed by law and shall make the addition or modification if the commissioner determines the addition or modification is warranted based on the best available evidence and research. If the commissioner wishes to add a delivery method under section 152.22, subdivision 6, or a qualifying medical condition under section 152.22, subdivision 14, the commissioner must notify the chairs and ranking minority members of the legislative policy committees having jurisdiction over health and public safety of the addition and the reasons for its addition, including any written comments received by the commissioner from the public and any guidance received from the task force on medical cannabis research, by January 15 of the year in which the commissioner wishes to make the change. The change shall be effective on August 1 of that year, unless the legislature by law provides otherwise.

Sec. 88. Minnesota Statutes 2018, section 152.27, subdivision 3, is amended to read:

Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application for enrollment into the registry program. The application shall be available to the patient and given to health care practitioners in the state who are eligible to serve as health care practitioners. The application must include:

(1) the name, mailing address, and date of birth of the patient;

(2) the name, mailing address, and telephone number of the patient's health care practitioner;

(3) the name, mailing address, and date of birth of the patient's designated caregiver, if any, or the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian, or spouse will be acting as a caregiver;

(4) a copy of the certification from the patient's health care practitioner that is dated within 90 days prior to submitting the application which certifies that the patient has been diagnosed with a qualifying medical condition and, if applicable, that, in the health care practitioner's medical opinion, the patient is developmentally or physically disabled and, as a result of that disability, the patient ~~is unable to self-administer medication~~ requires assistance in administering medical cannabis or ~~acquire~~ obtaining medical cannabis from a distribution facility; and

(5) all other signed affidavits and enrollment forms required by the commissioner under sections 152.22 to 152.37, including, but not limited to, the disclosure form required under paragraph (c).

(b) The commissioner shall require a patient to resubmit a copy of the certification from the patient's health care practitioner on a yearly basis and shall require that the recertification be dated within 90 days of submission.

(c) The commissioner shall develop a disclosure form and require, as a condition of enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

(1) a statement that, notwithstanding any law to the contrary, the commissioner, or an employee of any state agency, may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37; and

(2) the patient's ~~acknowledgement~~ acknowledgment that enrollment in the patient registry program is conditional on the patient's agreement to meet all of the requirements of sections 152.22 to 152.37.

Sec. 89. Minnesota Statutes 2018, section 152.27, subdivision 4, is amended to read:

Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a designated caregiver for a patient if the patient's health care practitioner has certified that the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability, the patient ~~is unable to self-administer medication or acquire~~ requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver has agreed, in writing, to be the patient's designated caregiver. As a condition of registration as a designated caregiver, the commissioner shall require the person to:

(1) be at least ~~21~~ 18 years of age;

(2) agree to only possess ~~any~~ the patient's medical cannabis for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not be a registered designated caregiver for more than one patient, unless the patients reside in the same residence.

(b) The commissioner shall conduct a criminal background check on the designated caregiver prior to registration to ensure that the person does not have a conviction for a disqualifying felony offense. Any cost of the background check shall be paid by the person seeking registration as a designated caregiver. A designated caregiver must have the criminal background check renewed every two years.

(c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered as a designated caregiver from also being enrolled in the registry program as a patient and possessing and using medical cannabis as a patient.

Sec. 90. Minnesota Statutes 2018, section 152.27, subdivision 5, is amended to read:

Subd. 5. **Parents ~~or~~, legal guardians, and spouses.** A parent ~~or~~, legal guardian, or spouse of a patient may act as the caregiver to the patient without having to register as a designated caregiver. The parent ~~or~~, legal guardian, or spouse shall follow all of the requirements of parents ~~and~~, legal guardians, and spouses listed in sections 152.22 to 152.37. Nothing in sections 152.22 to 152.37 limits any legal authority a parent ~~or~~, legal guardian, or spouse may have for the patient under any other law.

Sec. 91. Minnesota Statutes 2018, section 152.27, subdivision 6, is amended to read:

Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees, and signed disclosure, the commissioner shall enroll the patient in the registry program and

issue the patient and patient's registered designated caregiver or parent ~~or~~, legal guardian, or spouse, if applicable, a registry verification. The commissioner shall approve or deny a patient's application for participation in the registry program within 30 days after the commissioner receives the patient's application and application fee. The commissioner may approve applications up to 60 days after the receipt of a patient's application and application fees until January 1, 2016. A patient's enrollment in the registry program shall only be denied if the patient:

(1) does not have certification from a health care practitioner that the patient has been diagnosed with a qualifying medical condition;

(2) has not signed and returned the disclosure form required under subdivision 3, paragraph (c), to the commissioner;

(3) does not provide the information required;

(4) has previously been removed from the registry program for violations of section 152.30 or 152.33; or

(5) provides false information.

(b) The commissioner shall give written notice to a patient of the reason for denying enrollment in the registry program.

(c) Denial of enrollment into the registry program is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act pursuant to chapter 14.

(d) A patient's enrollment in the registry program may only be revoked upon the death of the patient or if a patient violates a requirement under section 152.30 or 152.33.

(e) The commissioner shall develop a registry verification to provide to the patient, the health care practitioner identified in the patient's application, and to the manufacturer. The registry verification shall include:

(1) the patient's name and date of birth;

(2) the patient registry number assigned to the patient; and

~~(3) the patient's qualifying medical condition as provided by the patient's health care practitioner in the certification; and~~

~~(4)~~ (3) the name and date of birth of the patient's registered designated caregiver, if any, or the name of the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian, or spouse will be acting as a caregiver.

Sec. 92. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in the registry program, a health care practitioner shall:

(1) determine, in the health care practitioner's medical judgment, whether a patient suffers from a qualifying medical condition, and, if so determined, provide the patient with a certification of that diagnosis;

(2) determine whether a patient is developmentally or physically disabled and, as a result of that disability, the patient ~~is unable to self-administer medication or acquire~~ requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility, and, if so determined, include that determination on the patient's certification of diagnosis;

(3) advise patients, registered designated caregivers, and parents ~~or~~, legal guardians, or spouses who are acting as caregivers of the existence of any nonprofit patient support groups or organizations;

(4) provide explanatory information from the commissioner to patients with qualifying medical conditions, including disclosure to all patients about the experimental nature of therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the proposed treatment; the application and other materials from the commissioner; and provide patients with the Tennessen warning as required by section 13.04, subdivision 2; and

(5) agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner.

(b) Upon notification from the commissioner of the patient's enrollment in the registry program, the health care practitioner shall:

(1) participate in the patient registry reporting system under the guidance and supervision of the commissioner;

(2) report health records of the patient throughout the ongoing treatment of the patient to the commissioner in a manner determined by the commissioner and in accordance with subdivision 2;

(3) determine, on a yearly basis, if the patient continues to suffer from a qualifying medical condition and, if so, issue the patient a new certification of that diagnosis; and

(4) otherwise comply with all requirements developed by the commissioner.

(c) A health care practitioner may conduct a patient assessment to issue a recertification as required under paragraph (b), clause (3), via telemedicine as defined under section 62A.671, subdivision 9.

~~(c)~~ (d) Nothing in this section requires a health care practitioner to participate in the registry program.

Sec. 93. Minnesota Statutes 2018, section 152.29, subdivision 1, is amended to read:

Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer shall operate ~~four~~ eight distribution facilities, which may include the manufacturer's single location for cultivation, harvesting, manufacturing, packaging, and processing but is not required to include that location. ~~A manufacturer is required to begin distribution of medical cannabis from at least one distribution facility by July 1, 2015. All distribution facilities must be operational and begin distribution of medical cannabis by July 1, 2016. The distribution facilities shall be located~~ The commissioner shall designate the geographical service areas to be served by each manufacturer based on geographical need throughout the state to improve patient access. ~~A manufacturer shall disclose the proposed locations for the distribution facilities to the commissioner during the registration process.~~ A manufacturer shall not have more than two distribution facilities in each geographical service area assigned to the manufacturer by the commissioner. A manufacturer shall operate only one location where all cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis shall be conducted. ~~Any~~ This location may be one of the manufacturer's distribution facility sites. The additional distribution facilities may dispense medical cannabis and medical cannabis products but may not contain any medical cannabis in a form other than those forms allowed under section 152.22, subdivision 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or processing at ~~an additional~~ the other distribution facility ~~site~~ sites. Any distribution facility operated by the manufacturer is subject to all of the requirements applying to the manufacturer under sections 152.22 to 152.37, including, but not limited to, security and distribution requirements.

(b) A manufacturer may acquire hemp grown in this state from a hemp grower. A manufacturer may manufacture or process hemp into an allowable form of medical cannabis under section 152.22, subdivision 6. Hemp acquired by a manufacturer under this paragraph is subject to the same quality control program, security and testing requirements, and other requirements that apply to medical cannabis under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

~~(b)~~ (c) A medical cannabis manufacturer shall contract with a laboratory approved by the commissioner, subject to any additional requirements set by the commissioner, for purposes of testing medical cannabis manufactured or hemp acquired by the medical cannabis manufacturer as to content, contamination, and consistency to verify the medical cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall be paid by the manufacturer.

~~(c)~~ (d) The operating documents of a manufacturer must include:

(1) procedures for the oversight of the manufacturer and procedures to ensure accurate record keeping; ~~and~~

(2) procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabis and unauthorized entrance into areas containing medical cannabis~~.~~; and

(3) procedures for the delivery and transportation of hemp between hemp growers and manufacturers.

~~(d)~~ (e) A manufacturer shall implement security requirements, including requirements for the delivery and transportation of hemp, protection of each location by a fully operational security alarm system, facility access controls, perimeter intrusion detection systems, and a personnel identification system.

~~(e)~~ (f) A manufacturer shall not share office space with, refer patients to a health care practitioner, or have any financial relationship with a health care practitioner.

~~(f)~~ (g) A manufacturer shall not permit any person to consume medical cannabis on the property of the manufacturer.

~~(g)~~ (h) A manufacturer is subject to reasonable inspection by the commissioner.

~~(h)~~ (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

~~(i)~~ (j) A medical cannabis manufacturer may not employ any person who is under 21 years of age or who has been convicted of a disqualifying felony offense. An employee of a medical cannabis manufacturer must submit a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees for submission to the Bureau of Criminal Apprehension before an employee may begin working with the manufacturer. The bureau must conduct a Minnesota criminal history records check and the superintendent is authorized to exchange the fingerprints with the Federal Bureau of

Investigation to obtain the applicant's national criminal history record information. The bureau shall return the results of the Minnesota and federal criminal history records checks to the commissioner.

~~(j)~~ (k) A manufacturer may not operate in any location, whether for distribution or cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a public or private school existing before the date of the manufacturer's registration with the commissioner.

~~(k)~~ (l) A manufacturer shall comply with reasonable restrictions set by the commissioner relating to signage, marketing, display, and advertising of medical cannabis.

(m) Before a manufacturer acquires hemp from a hemp grower, the manufacturer must verify that the hemp grower has a valid license issued by the commissioner of agriculture under chapter 18K.

Sec. 94. Minnesota Statutes 2018, section 152.29, subdivision 2, is amended to read:

Subd. 2. **Manufacturer; production.** (a) A manufacturer of medical cannabis shall provide a reliable and ongoing supply of all medical cannabis needed for the registry program through cultivation by the manufacturer and through the purchase of hemp from hemp growers.

(b) All cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis must take place in an enclosed, locked facility at a physical address provided to the commissioner during the registration process.

(c) A manufacturer must process and prepare any medical cannabis plant material or hemp plant material into a form allowable under section 152.22, subdivision 6, prior to distribution of any medical cannabis.

Sec. 95. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval for the distribution of medical cannabis to a patient. A manufacturer may transport medical cannabis or medical cannabis products that have been cultivated, harvested, manufactured, packaged, and processed by that manufacturer to another registered manufacturer for the other manufacturer to distribute.

(b) A manufacturer may ~~dispense~~ distribute medical cannabis products, whether or not the products have been manufactured by ~~the~~ that manufacturer~~, but is not required to dispense medical cannabis products~~.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent ~~or~~, legal guardian, or spouse listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely using a videoconference, so long as the employee providing the consultation is able to confirm the identity of the patient, the consultation occurs while the patient is at a distribution facility, and the consultation adheres to patient privacy requirements that apply to health care services delivered through telemedicine;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent or legal guardian, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a ~~30-day~~ 90-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis products to a distribution facility or to another registered manufacturer to carry identification showing that the person is an employee of the manufacturer.

Sec. 96. Minnesota Statutes 2018, section 152.29, subdivision 3a, is amended to read:

Subd. 3a. **Transportation of medical cannabis; staffing.** (a) A medical cannabis manufacturer may staff a transport motor vehicle with only one employee if the medical cannabis manufacturer is transporting medical cannabis to either a certified laboratory for the purpose of testing or a facility for the purpose of disposal. If the medical cannabis manufacturer is transporting medical cannabis for any other purpose or destination, the transport motor vehicle must be staffed with a minimum of two employees as required by rules adopted by the commissioner.

(b) Notwithstanding paragraph (a), a medical cannabis manufacturer that is only transporting hemp for any purpose may staff the transport motor vehicle with only one employee.

Sec. 97. Minnesota Statutes 2018, section 152.31, is amended to read:

152.31 DATA PRACTICES.

(a) Government data in patient files maintained by the commissioner and the health care practitioner, and data submitted to or by a medical cannabis manufacturer, are private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13 and complying with a request from the legislative auditor or the state auditor in the performance of official duties. The provisions of section 13.05, subdivision 11, apply to a registration agreement entered between the commissioner and a medical cannabis manufacturer under section 152.25.

(b) Not public data maintained by the commissioner may not be used for any purpose not provided for in sections 152.22 to 152.37, and may not be combined or linked in any manner with any other list, dataset, or database.

(c) The commissioner may execute data sharing arrangements with the commissioner of agriculture to verify licensing, inspection, and compliance information related to hemp growers under chapter 18K.

Sec. 98. Minnesota Statutes 2018, section 152.32, subdivision 2, is amended to read:

Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following are not violations under this chapter:

(1) use or possession of medical cannabis or medical cannabis products by a patient enrolled in the registry program, or possession by a registered designated caregiver or the parent ~~or~~, legal guardian, or spouse of a patient if the parent ~~or~~, legal guardian, or spouse is listed on the registry verification;

(2) possession, dosage determination, or sale of medical cannabis or medical cannabis products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory conducting testing on medical cannabis, or employees of the laboratory; and

(3) possession of medical cannabis or medical cannabis products by any person while carrying out the duties required under sections 152.22 to 152.37.

(b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and associated property is not subject to forfeiture under sections 609.531 to 609.5316.

(c) The commissioner, the commissioner's staff, the commissioner's agents or contractors, and any health care practitioner are not subject to any civil or disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any business, occupational, or professional licensing board or entity, solely for the participation in the registry program under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional licensing board from taking action in response to violations of any other section of law.

(d) Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37.

(e) Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid search warrant.

(f) Notwithstanding any law to the contrary, neither the commissioner nor a public employee may release data or information about an individual contained in any report, document, or registry created under sections 152.22 to 152.37 or any information obtained about a patient participating in the program, except as provided in sections 152.22 to 152.37.

(g) No information contained in a report, document, or registry or obtained from a patient under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding unless independently obtained or in connection with a proceeding involving a violation of sections 152.22 to 152.37.

(h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty of a gross misdemeanor.

(i) An attorney may not be subject to disciplinary action by the Minnesota Supreme Court or professional responsibility board for providing legal assistance to prospective or registered manufacturers or others related to activity that is no longer subject to criminal penalties under state law pursuant to sections 152.22 to 152.37.

(j) Possession of a registry verification or application for enrollment in the program by a person entitled to possess or apply for enrollment in the registry program does not constitute probable cause or reasonable suspicion, nor shall it be used to support a search of the person or property of the person possessing or applying for the registry verification, or otherwise subject the person or property of the person to inspection by any governmental agency.

Sec. 99. Minnesota Statutes 2018, section 152.33, subdivision 1, is amended to read:

Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally transfers medical cannabis to a person other than another registered manufacturer, a patient, a registered designated caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both. A person convicted under this subdivision may not continue to be affiliated with the manufacturer and is disqualified from further participation under sections 152.22 to 152.37.

Sec. 100. Minnesota Statutes 2018, section 152.33, subdivision 2, is amended to read:

Subd. 2. **Diversion by patient, registered designated caregiver, ~~or~~ parent, legal guardian, or patient's spouse; criminal penalty.** In addition to any other applicable penalty in law, a patient, registered designated caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient who intentionally sells or otherwise transfers medical cannabis to a person other than a patient, designated registered caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both.

Sec. 101. Minnesota Statutes 2018, section 152.34, is amended to read:

152.34 HEALTH CARE FACILITIES.

(a) Health care facilities licensed under chapter 144A, hospice providers licensed under chapter 144A, boarding care homes or supervised living facilities licensed under section 144.50, assisted living facilities, ~~and~~ facilities owned, controlled, managed, or under common control with hospitals licensed under chapter 144, and other health facilities licensed by the commissioner of health, may adopt reasonable restrictions on the use of medical cannabis by a patient enrolled in the registry program who resides at or is actively receiving treatment or care at the facility. The restrictions may include a provision that the facility will not store or maintain the patient's supply of medical cannabis, that the facility is not responsible for providing the medical cannabis for patients, and that medical cannabis be used only in a place specified by the facility.

(b) Any employee or agent of a facility listed in this section or a person licensed under chapter 144E is not subject to violations under this chapter for possession of medical cannabis while carrying out employment duties, including providing or supervising care to a registered patient, or distribution of medical cannabis to a registered patient who resides at or is actively receiving treatment or care at the facility with which the employee or agent is affiliated. Nothing in this section shall require the facilities to adopt such restrictions and no facility shall unreasonably limit a patient's access to or use of medical cannabis to the extent that use is authorized by the patient under sections 152.22 to 152.37.

Sec. 102. Minnesota Statutes 2018, section 152.36, subdivision 2, is amended to read:

Subd. 2. **Impact assessment.** The task force shall hold hearings to evaluate the impact of the use of medical cannabis and hemp and Minnesota's activities involving medical cannabis and hemp, including, but not limited to:

(1) program design and implementation;

(2) the impact on the health care provider community;

(3) patient experiences;

(4) the impact on the incidence of substance abuse;

(5) access to and quality of medical cannabis, hemp, and medical cannabis products;

(6) the impact on law enforcement and prosecutions;

(7) public awareness and perception; and

(8) any unintended consequences.

Sec. 103. Minnesota Statutes 2018, section 157.22, is amended to read:

157.22 EXEMPTIONS.

This chapter does not apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) weddings, fellowship meals, or funerals conducted by a faith-based organization using any building constructed and primarily used for religious worship or education;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods;

(7) fraternal, sportsman, or patriotic organizations that are tax exempt under section 501(c)(3), 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of 1986, or organizations related to, affiliated with, or supported by such fraternal, sportsman, or patriotic organizations for events held in the building or on the grounds of the organization and at which home-prepared food is donated by organization members for sale at the events, provided:

(i) the event is not a circus, carnival, or fair;

(ii) the organization controls the admission of persons to the event, the event agenda, or both; and

(iii) the organization's licensed kitchen is not used in any manner for the event;

(8) food not prepared at an establishment and brought in by individuals attending a potluck event for consumption at the potluck event. An organization sponsoring a potluck

event under this clause may advertise the potluck event to the public through any means. Individuals who are not members of an organization sponsoring a potluck event under this clause may attend the potluck event and consume the food at the event. Licensed food establishments other than schools cannot be sponsors of potluck events. A school may sponsor and hold potluck events in areas of the school other than the school's kitchen, provided that the school's kitchen is not used in any manner for the potluck event. For purposes of this clause, "school" means a public school as defined in section 120A.05, subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization at which a child is provided with instruction in compliance with sections 120A.22 and 120A.24. Potluck event food shall not be brought into a licensed food establishment kitchen;

(9) a home school in which a child is provided instruction at home;

(10) school concession stands serving commercially prepared, nonpotentially hazardous foods, as defined in Minnesota Rules, chapter 4626;

(11) group residential facilities of ten or fewer beds licensed by the commissioner of human services under Minnesota Rules, chapter 2960, provided the facility employs or contracts with a certified food manager under Minnesota Rules, part 4626.2015;

(12) food served at fund-raisers or community events conducted in the building or on the grounds of a faith-based organization, provided that a certified food manager, or a volunteer trained in a food safety course, trains the food preparation workers in safe food handling practices. This exemption does not apply to faith-based organizations at the state agricultural society or county fairs or to faith-based organizations that choose to apply for a license;

(13) food service events conducted following a disaster for purposes of feeding disaster relief staff and volunteers serving commercially prepared, nonpotentially hazardous foods, as defined in Minnesota Rules, chapter 4626; ~~and~~

(14) chili or soup served at a chili or soup cook-off fund-raiser conducted by a community-based nonprofit organization, provided:

(i) the municipality where the event is located approves the event;

(ii) the sponsoring organization must develop food safety rules and ensure that participants follow these rules; and

(iii) if the food is not prepared in a kitchen that is licensed or inspected, a visible sign or placard must be posted that states: "These products are homemade and not subject to state inspection."

Foods exempt under this clause must be labeled to accurately reflect the name and address of the person preparing the foods.; and

(15) a special event food stand or a seasonal temporary food stand provided:

(i) the stand is located on private property with the permission of the property owner;

(ii) the stand has gross receipts or contributions of $1,000 or less in a calendar year; and

(iii) the operator of the stand posts a sign or placard at the site that states "The products sold at this stand are not subject to state inspection or regulation.", if the stand offers for sale potentially hazardous food as defined in Minnesota Rules, part 4626.0020, subdivision 62.

Sec. 104. Minnesota Statutes 2018, section 214.25, subdivision 2, is amended to read:

Subd. 2. **Commissioner of health data.** ~~(a)~~ All data collected or maintained as part of the commissioner of health's duties under Minnesota Statutes 2018, sections 214.19, 214.23, and 214.24, shall be classified as investigative data under section 13.39, except that inactive investigative data shall be classified as private data under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, in the case of data not on individuals.

~~(b) Notwithstanding section 13.05, subdivision 9, data addressed in this subdivision shall not be disclosed except as provided in this subdivision or section 13.04; except that the commissioner may disclose to the boards under section 214.23.~~

~~(c) The commissioner may disclose data addressed under this subdivision as necessary: to identify, establish, implement, and enforce a monitoring plan; to investigate a regulated person; to alert persons who may be threatened by illness as evidenced by epidemiologic data; to control or prevent the spread of HIV, HBV, or HCV disease; or to diminish an imminent threat to the public health.~~

EFFECTIVE DATE. This section is effective on January 1, 2020, and no new cases shall be investigated under this subdivision after June 1, 2019.

Sec. 105. Laws 2019, chapter 60, article 3, section 1, subdivision 5, is amended to read:

Subd. 5. **Notice to facility; exceptions.** (a) Electronic monitoring may begin only after the resident or resident representative who intends to place an electronic monitoring device and any roommate or roommate's resident representative completes the notification and consent form and submits the form to the facility.

(b) Notwithstanding paragraph (a), the resident or resident representative who intends to place an electronic monitoring device may do so without submitting a notification and consent form to the facility for up to 14 days:

(1) if the resident or the resident representative reasonably fears retaliation against the resident by the facility, timely submits the completed notification and consent form to the Office of Ombudsman for Long-Term Care, and timely submits a Minnesota Adult Abuse Reporting Center report or police report, or both, upon evidence from the electronic monitoring device that suspected maltreatment has occurred;

(2) if there has not been a timely written response from the facility to a written communication from the resident or resident representative expressing a concern prompting the desire for placement of an electronic monitoring device and if the resident or a resident representative timely submits a completed notification and consent form to the Office of Ombudsman for Long-Term Care; or

(3) if the resident or resident representative has already submitted a Minnesota Adult Abuse Reporting Center report or police report regarding the resident's concerns prompting the desire for placement and if the resident or a resident representative timely submits a completed notification and consent form to the Office of Ombudsman for Long-Term Care.

(c) Upon receipt of any completed notification and consent form, the facility must place the original form in the resident's file or file the original form with the resident's housing with services contract. The facility must provide a copy to the resident and the resident's roommate, if applicable.

(d) If a resident is conducting electronic monitoring according to paragraph (b) and ~~obtains a signed notification and consent form from a roommate~~ a new roommate moves into the room or living unit, the resident or resident representative must submit the signed notification and consent form to the facility. In the event that a resident or roommate, or the resident representative or roommate's resident representative if the representative is consenting on behalf of the resident or roommate, chooses to alter the conditions under which consent to electronic monitoring is given or chooses to withdraw consent to electronic monitoring, the facility must make available the original notification and consent form so that it may be updated. Upon receipt of the updated form, the facility must place the updated form in the resident's file or file the original form with the resident's signed housing with services contract. The facility must provide a copy of the updated form to the resident and the resident's roommate, if applicable.

(e) If a new roommate, or the new roommate's resident representative when consenting on behalf of the new roommate, does not submit to the facility a completed notification and consent form and the resident conducting the electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

(f) If a roommate, or the roommate's resident representative when withdrawing consent on behalf of the roommate, submits an updated notification and consent form withdrawing consent and the resident conducting electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to all agreements in effect, entered into, or renewed on or after that date.

Sec. 106. **PLAN FOR A WORKING GROUP ON LINKS BETWEEN HEALTH DISPARITIES AND EDUCATIONAL ACHIEVEMENT FOR CHILDREN FROM AMERICAN INDIAN COMMUNITIES AND COMMUNITIES OF COLOR.**

(a) The commissioner of health, in consultation with the commissioner of education, shall develop a plan to convene one or more working groups to:

(1) examine the links between health disparities and disparities in educational achievement for children from American Indian communities and communities of color; and

(2) develop recommendations for programs, services, or funding to address health disparities and decrease disparities in educational achievement for children from American Indian communities and communities of color.

(b) The plan shall include the possible membership of the proposed working group and the duties for the proposed working group.

(c) The commissioner shall submit the plan for the working group, including proposed legislation establishing the working group, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and education by February 15, 2020.

Sec. 107. **COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the community solutions for healthy child development grant program. The purposes of the program are to:

(1) improve child development outcomes as related to the well-being of children of color and American Indian children from prenatal to grade 3 and their families, including but not limited to the goals outlined by the Department of Human Service's early childhood systems reform effort: early learning; health and well-being; economic security; and safe, stable, nurturing relationships and environments by funding community-based solutions for challenges that are identified by the affected community;

(2) reduce racial disparities in children's health and development, from prenatal to grade 3; and

(3) promote racial and geographic equity.

Subd. 2. **Commissioner's duties.** The commissioner of health shall:

(1) develop a request for proposals for the healthy child development grant program in consultation with the Community Solutions Advisory Council;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing service providers in order to better meet statewide needs, particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) review responses to requests for proposals, in consultation with the Community Solutions Advisory Council, and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the governor's early learning council on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with the Community Solutions Advisory Council, focused on outcomes that grantees agree to achieve;

(6) provide grantees with access to data to assist grantees in establishing and implementing effective community-led solutions;

(7) maintain data on outcomes reported by grantees; and

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities of children of color and American Indian children from prenatal to grade 3.

Subd. 3. **Community Solutions Advisory Council; establishment; duties; compensation.** (a) No later than October 1, 2019, the commissioner shall convene a 12-member Community Solutions Advisory Council as follows:

(1) two members representing the African Heritage community;

(2) two members representing the Latino community;

(3) two members representing the Asian-Pacific Islander community;

(4) two members representing the American Indian community;

(5) two parents of children of color or that are American Indian with children under nine years of age;

(6) one member with research or academic expertise in racial equity and healthy child development; and

(7) one member representing an organization that advocates on behalf of communities of color or American Indians.

(b) At least three of the 12 members of the advisory council must come from outside the seven-county metropolitan area.

(c) The Community Solutions Advisory Council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

(2) review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards;

(3) advise the commissioner on the establishment of a transparent and objective accountability process focused on outcomes the grantees agree to achieve;

(4) advise the commissioner on ongoing oversight and necessary support in the implementation of the program; and

(5) support the commissioner on other racial equity and early childhood grant efforts.

(d) Each advisory council member shall be compensated in accordance with Minnesota Statutes, section 15.059, subdivision 3.

Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this section include:

(1) organizations or entities that work with communities of color and American Indian communities;

(2) tribal nations and tribal organizations as defined in section 658P of the Child Care and Development Block Grant Act of 1990; and

(3) organizations or entities focused on supporting healthy child development.

Subd. 5. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with the Community Solutions Advisory Council, shall develop a request for proposals for healthy child development grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. Proposals must focus on increasing racial equity and healthy child development and reducing health disparities experienced by children of color and American Indian children from prenatal to grade 3 and their families.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from:

(1) organizations or entities led by people of color and serving communities of color;

(2) organizations or entities led by American Indians and serving American Indians, including tribal nations and tribal organizations;

(3) organizations or entities with proposals focused on healthy development from prenatal to age three;

(4) organizations or entities with proposals focusing on multigenerational solutions;

(5) organizations or entities located in or with proposals to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report; and

(6) community-based organizations that have historically served communities of color and American Indians and have not traditionally had access to state grant funding.

The advisory council may recommend additional strategic considerations and priorities to the commissioner.

(c) The first round of grants must be awarded no later than April 15, 2020.

Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of people of color and American Indians than the state average, to the extent possible.

Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 108. **DOMESTIC VIOLENCE AND SEXUAL ASSAULT PREVENTION PROGRAM.**

Subdivision 1. **Program establishment.** The commissioner of health shall administer the domestic violence and sexual assault prevention program as established under this section.

Subd. 2. **Grant criteria.** (a) The commissioner shall award grants to nonprofit organizations for the purpose of funding programs that incorporate community-driven and culturally relevant practices to prevent domestic violence and sexual assault. Grants made pursuant to this section may either (1) encourage the development and deployment of new prevention efforts, or (2) enhance, sustain, or expand existing prevention efforts.

(b) The commissioner of health shall award grants to nonprofit organizations supporting activities that:

(1) promote the general development of domestic violence and sexual assault prevention programs and activities;

(2) implement prevention activities through community outreach that address the root causes of domestic violence and sexual assault;

(3) identify risk and protective factors for developing domestic violence and sexual assault prevention strategies and outreach activities;

(4) provide trauma-informed domestic violence and sexual assault prevention services;

(5) educate youth and adults about healthy relationships and changing social norms;

(6) develop culturally and linguistically appropriate domestic violence and sexual assault prevention programs for historically underserved communities;

(7) work collaboratively with educational institutions, including school districts, to implement domestic violence and sexual assault prevention strategies for students, teachers, and administrators; or

(8) work collaboratively with other nonprofit organizations, for-profit organizations, and other community-based organizations to implement domestic violence and sexual assault prevention strategies within their communities.

Subd. 3. **Definition.** For purposes of this section, "domestic violence and sexual assault" includes, but is not limited to, the following:

(1) intimate partner violence, including emotional, psychological, and economic abuse;

(2) sex trafficking as defined in Minnesota Statutes, section 609.321, subdivision 7a;

(3) domestic abuse as defined in Minnesota Statutes, section 518B.01, subdivision 2;

(4) any criminal sexual conduct crime in Minnesota Statutes, sections 609.342 to 609.3453;

(5) abusive international marriage;

(6) forced marriage; and

(7) female genital mutilation, as defined in Minnesota Statutes, section 609.2245, subdivision 1.

Subd. 4. **Promotion; administration.** The commissioner may spend up to 15 percent of the total program funding for each fiscal year to promote and administer the program authorized under this section and to provide technical assistance to program grantees.

Subd. 5. **Nonstate sources.** The commissioner may accept contributions from nonstate sources to supplement state appropriations for the program authorized under this section. Contributions received under this subdivision are appropriated to the commissioner for purposes of this section.

Subd. 6. **Program evaluation.** (a) The commissioner of health shall report by February 28 of each even-numbered year to the legislative committees with jurisdiction over health detailing the expenditures of funds authorized under this section. The commissioner shall use the data to evaluate the effectiveness of the program. The commissioner must include in the report:

(1) the number of organizations receiving grant money under this section;

(2) the number of individuals served by the grant program;

(3) a description and analysis of the practices implemented by program grantees; and

(4) best practices recommendations to prevent domestic violence and sexual assault, including best practices recommendations that are culturally relevant to historically underserved communities.

(b) Any organization receiving grant money under this section must collect and make available to the commissioner of health aggregate data related to the activity funded by the grant program under this section.

(c) The commissioner of health shall use the information and data from the program evaluation under paragraph (a), including best practices and culturally specific responses,

to inform the administration of existing Department of Health programming and the development of Department of Health policies, programs, and procedures.

Sec. 109. **SKIN LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of increasing public awareness and education on the health dangers associated with using skin lightening creams and products that contain mercury that are manufactured in other countries and brought into this country and sold illegally online or in stores.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposals process to community-based organizations serving ethnic communities, local public health entities, and nonprofit organizations that focus on providing health care and public health outreach to minorities. Priority shall be given to organizations that have historically served ethnic communities at significant risk from these products, but have not traditionally had access to state grant funding.

Subd. 3. **Grant allocation.** (a) Grantees must use the funds to conduct public awareness and education activities that are culturally specific and community-based and focus on:

(1) the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and through contact with individuals who have used these skin lightening products;

(2) the signs and symptoms of mercury poisoning;

(3) the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys;

(4) the dangers of using these products or being exposed to these products during pregnancy and breastfeeding to the mother and to the infant;

(5) knowing how to identify products that contain mercury; and

(6) proper disposal of the product if the product contains mercury.

(b) The grant application must include:

(1) a description of the purpose or project for which the grant funds will be used;

(2) a description of the objectives, a work plan, and a timeline for implementation; and

(3) the community or group the grant proposes to focus on.

(c) The commissioner shall award 50 percent of the grant funds to community-based organizations and nonprofit organizations and 50 percent of the funds to local public health entities.

Sec. 110. **SALE OF CERTAIN CANNABINOID PRODUCTS WORKGROUP.**

(a) The commissioner of health, in consultation with the commissioners of commerce, agriculture, and public safety, and the executive director of the Board of Pharmacy, shall convene a workgroup to advise the legislature on how to regulate products that contain cannabinoids extracted from hemp. For purposes of this section, "hemp" has the meaning given to "industrial hemp" in Minnesota Statutes, section 18K.02, subdivision 3.

(b) The commissioner shall assess the public health and consumer safety impact on the sale of cannabinoids derived from hemp and shall develop a regulatory framework of what the legislature would need to consider including, but not limited to:

(1) cultivation standards for industrial hemp if the hemp is used for any product intended for human or animal consumption;

(2) labeling requirements for products containing cannabidiol extracted from hemp, including the amount and percentage of cannabidiol in the product, the name of the manufacturer of the product, and the ingredients contained in the product;

(3) possible restrictions of advertising and marketing of the cannabidiol product;

(4) restrictions of false, misleading, or unsubstantiated health claims;

(5) requirements for the independent testing of cannabidiol products, including quality control and chemical identification;

(6) safety standards for edible products containing cannabinoids extracted from hemp, including container and packaging requirements; and

(7) any other requirement or procedure the commissioner deems necessary.

(c) By January 15, 2020, the commissioner of health shall submit the results of the workgroup to the chairs and ranking minority members of the legislative committees with jurisdiction over public health, consumer protection, public safety, and agriculture.

Sec. 111. **REVISOR INSTRUCTION.**

The revisor of statutes shall correct any internal cross-references to Minnesota Statutes, sections 214.17 to 214.25, that occur as a result of the repealed language and may make

changes necessary to correct punctuation, grammar, or structure of the remaining text and preserve its meaning.

Sec. 112. **REPEALER.**

(a) Minnesota Statutes 2018, sections 144.414, subdivision 5; 144A.45, subdivision 6; and 144A.481, are repealed.

(b) Minnesota Statutes 2018, sections 214.17; 214.18; 214.19; 214.20; 214.21; 214.22; 214.23; and 214.24, are repealed on January 1, 2020, and no new cases shall be investigated under these sections after June 1, 2019.

ARTICLE 12
MISCELLANEOUS

Section 1. **[10.584] MATERNAL MENTAL HEALTH AWARENESS MONTH.**

The month of May is designated as Maternal Mental Health Awareness Month in recognition of the state's desire to recognize the prevalence of pregnancy and postpartum mental health issues and educate the people of the state about identifying symptoms and seeking treatment options. Up to one-third of mothers report having symptoms of pregnancy and postpartum mood and anxiety disorders each year. Many more cases go unreported due to misunderstanding. Pregnancy and postpartum mood disorders are widespread but treatable illnesses. Left untreated, pregnancy and postpartum mood and anxiety disorders can lead to negative effects on birth outcomes, infant development, and the well-being of mothers and families. The state declares that in order to educate the public, the governor may promote and encourage the observance of Maternal Mental Health Awareness Month.

ARTICLE 13
FORECAST ADJUSTMENT

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2019" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2019.

APPROPRIATIONS
Available for the Year

		Ending June 30	
		2019	
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**		**$**	**(318,423,000)**
	Appropriations by Fund		
	2019		
General	(317,538,000)		
Health Care Access	8,410,000		
Federal TANF	(9,295,000)		
Subd. 2. **Forecasted Programs**			
(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**			
	Appropriations by Fund		
General	(19,361,000)		
Federal TANF	(8,893,000)		
(b) **MFIP Child Care Assistance**			(16,789,000)
(c) **General Assistance**			(7,928,000)
(d) **Minnesota Supplemental Aid**			(549,000)
(e) **Housing Support**			(13,836,000)
(f) **Northstar Care for Children**			(19,027,000)
(g) **MinnesotaCare**			8,410,000
This appropriation is from the health care access fund.			
(h) **Medical Assistance**			
	Appropriations by Fund		
General	(222,176,000)		
Health Care Access	-0-		
(i) **Alternative Care**			-0-
(j) **Consolidated Chemical Dependency Treatment Fund (CCDTF) Entitlement**			(17,872,000)

Subd. 3. **Technical Activities** (402,000)

This appropriation is from the federal TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 14

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2020" and "2021" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively. "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium" is fiscal years 2020 and 2021.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2020	**2021**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 8,148,863,000**	**$ 8,400,601,000**

Appropriations by Fund

	2020	2021
General	7,221,990,000	7,320,071,000
State Government Special Revenue	4,299,000	4,299,000
Health Care Access	661,393,000	795,115,000
Federal TANF	259,285,000	279,220,000
Lottery Prize	1,896,000	1,896,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(7) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (7), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Certain Expenditures Required.** The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) **Limitation; Exceptions.** The commissioner must not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section

264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) **Supplemental Expenditures.** For the purposes of paragraph (d), the commissioner may supplement the MOE claim with other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(i) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2020 and 2021 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	152,240,000	151,012,000
State Government Special Revenue	4,174,000	4,174,000
Health Care Access	20,709,000	20,724,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) the statewide data management system authorized in Minnesota Statutes, section 125A.744, subdivision 3;

(2) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 245.495, paragraph (b);

(3) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) targeted case management under Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) residential services for children with severe emotional disturbance under Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Child Care Licensing Inspections.** $673,000 in fiscal year 2020 and $722,000 in fiscal year 2021 are from the general fund to add eight child care licensing staff for the purpose of increasing the frequency of inspections of child care centers to ensure the health and safety of children in care, provide

technical assistance to newly licensed programs, and monitor struggling programs more closely to evaluate whether the program should be referred to the Office of Inspector General for a potential fraud investigation.

(c) **Child Care Assistance Programs - Fraud and Abuse Data Analysts.** $317,000 in fiscal year 2020 and $339,000 in fiscal year 2021 are from the general fund to add two data analysts to strengthen the commissioner's ability to identify, detect, and prevent fraud and abuse in the child care assistance programs under Minnesota Statutes, chapter 119B.

(d) **Office of Inspector General Investigators.** $418,000 in fiscal year 2020 and $483,000 in fiscal year 2021 are from the general fund to add four investigators to the Office of Inspector General to detect, prevent, and make recoveries from fraudulent activities among providers in the medical assistance program under Minnesota Statutes, chapter 256B.

(e) **Office of Inspector General Tracking System.** $355,000 in fiscal year 2020 and $105,000 in fiscal year 2021 are from the general fund to purchase a system to record, track, and report on investigative activity for the Office of Inspector General to strengthen fraud prevention and investigation activities for child care assistance programs under Minnesota Statutes, chapter 119B.

(f) **Fraud Prevention Investigation Grant Program.** $425,000 in fiscal year 2020 and $425,000 in fiscal year 2021 are from the general fund for the fraud prevention

investigation grant program under Minnesota Statutes, section 256.983.

(g) **Child Care Assistance Programs - Law Enforcement.** $350,000 in fiscal year 2020 and $350,000 in fiscal year 2021 are from the general fund to add two additional law enforcement officers under contract with the Bureau of Criminal Apprehension to conduct criminal investigations in child care assistance program cases.

(h) **Transfer; Long-Term Care Options Account.** By June 30, 2020, the commissioner shall transfer $3,242,000 from the long-term care options account authorized in Minnesota Statutes, section 256.01, subdivision 34, to the general fund. This is a onetime transfer.

(i) **Transfer to Office of Legislative Auditor.** $300,000 in fiscal year 2020 and $300,000 in fiscal year 2021 are from the general fund for transfer to the Office of the Legislative Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2b.

(j) **Transfer to Office of Legislative Auditor.** $400,000 in fiscal year 2020 and $400,000 in fiscal year 2021 are from the general fund for transfer to the Office of the Legislative Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2a.

(k) **Family Child Care Task Force.** $121,000 in fiscal year 2020 is from the general fund for the Family Child Care Task Force under article 2, section 130. This is a onetime appropriation.

(l) **Base Level Adjustment.** The general fund base is $142,929,000 in fiscal year 2022 and $145,377,000 in fiscal year 2023. The health care access base is $20,712,000 in fiscal year 2022 and $20,712,000 in fiscal year 2023.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	13,558,000	14,424,000
Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 in fiscal year 2020 and $310,000 in fiscal year 2021 from the state systems account authorized in Minnesota Statutes, section 256.014, subdivision 2, to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Child Welfare Training Academy.** $1,371,000 in fiscal year 2020 and $2,517,000 in fiscal year 2021 are from the general fund for the Child Welfare Training Academy for the provision of child protection worker training under Minnesota Statutes, section 626.5591, subdivision 2. The base for this appropriation is $2,754,000 in fiscal year 2022 and $3,007,000 in fiscal year 2023.

(c) **Child Care Assistance Programs - Improvements.** $105,000 in fiscal year 2020 and $120,000 in fiscal year 2021 are from the general fund to add one temporary staff person

to plan for improvements to provider registration and oversight for the child care assistance programs under Minnesota Statutes, chapter 119B. This is a onetime appropriation.

(d) **Base Level Adjustment.** The general fund base is $14,540,000 in fiscal year 2022 and $14,793,000 in fiscal year 2023.

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	22,769,000	23,678,000
Health Care Access	25,063,000	24,406,000

(a) **Nonemergency Medical Transportation Program Audits.** $557,000 in fiscal year 2020 and $1,119,000 in fiscal year 2021 are from the general fund to conduct audits of the nonemergency medical transportation program. The base for this appropriation is $1,123,000 in fiscal year 2022 and $1,123,000 in fiscal year 2023.

(b) **Outpatient Pharmacy.** $113,000 in fiscal year 2020 and $50,000 in fiscal year 2021 are from the general fund to contract for 340B pharmacy data in order to perform the new pricing calculations and conduct a cost of dispensing survey. The base for this appropriation is $50,000 in fiscal year 2022 and $163,000 in fiscal year 2023.

(c) **Base Level Adjustment.** The general fund base is $24,028,000 in fiscal year 2022 and $23,697,000 in fiscal year 2023. The health care access fund base is $24,422,000 in fiscal year 2022 and $24,422,000 in fiscal year 2023.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	14,670,000	14,677,000
State Government Special Revenue	125,000	125,000

Subd. 7. **Central Office; Community Supports**

	Appropriations by Fund	
General	35,722,000	35,741,000
Lottery Prize	163,000	163,000

(a) **Community Competency Restoration Task Force.** $125,000 in fiscal year 2020 and $75,000 in fiscal year 2021 are for the Community Competency Restoration Task Force under article 6, section 78. This is a onetime appropriation and is available until June 30, 2023.

(b) **Base Level Adjustment.** The general fund base is $35,680,000 in fiscal year 2022 and $35,599,000 in fiscal year 2023.

Subd. 8. **Forecasted Programs; MFIP/DWP**

	Appropriations by Fund	
General	83,886,000	90,149,000
Federal TANF	84,267,000	97,771,000

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance**	102,061,000	101,855,000
Subd. 10. **Forecasted Programs; General Assistance**	49,959,000	50,586,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2020 and $6,729,812 in fiscal year 2021. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 11. **Forecasted Programs; Minnesota Supplemental Aid**	42,348,000	46,420,000
Subd. 12. **Forecasted Programs; Housing Support**	169,610,000	170,218,000
Subd. 13. **Forecasted Programs; Northstar Care for Children**	86,497,000	94,095,000
Subd. 14. **Forecasted Programs; MinnesotaCare**	25,197,000	143,937,000

This appropriation is from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	5,515,098,000	5,565,150,000
Health Care Access	586,959,000	602,583,000

(a) **Behavioral Health Services.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

(b) **Base Level Adjustment.** The health care access fund base is $611,178,000 in fiscal year 2022 and $612,099,000 in fiscal year 2023.

Subd. 16. **Forecasted Programs; Alternative Care** 45,246,000 45,276,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 17. **Forecasted Programs; Chemical Dependency Treatment Fund** 124,719,000 135,609,000

Transfer; Consolidated Chemical Dependency Treatment Fund. Any balance remaining in the consolidated chemical dependency treatment fund at the end of fiscal year 2020, estimated to be $23,855,000, shall be transferred to the general fund.

Subd. 18. **Grant Programs; Support Services Grants**

Appropriations by Fund		
General	8,715,000	8,715,000
Federal TANF	96,312,000	96,311,000

Subd. 19. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 44,655,000 53,616,000

Subd. 20. **Grant Programs; Child Care Development Grants** 1,737,000 1,737,000

Subd. 21. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 22. **Grant Programs; Children's Services Grants**

Appropriations by Fund		
General	44,207,000	48,785,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** The commissioner shall allocate funds from the Title IV-E reimbursement to the state from the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster,

and kinship families as required in Minnesota Statutes, section 256N.261.

Additional federal reimbursement 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 is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

(b) **Parent Support for Better Outcomes Grants.** $150,000 in fiscal year 2020 and $150,000 in fiscal year 2021 are from the general fund for grants to Minnesota One-Stop for Communities to provide mentoring, guidance, and support services to parents navigating the child welfare system in Minnesota in order to promote the development of safe, stable, and healthy families. Grant funds may be used for parent mentoring, peer-to-peer support groups, housing support services, training, staffing, and administrative costs. This is a onetime appropriation.

(c) **Safe Harbor for Sexually Exploited Youth.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are from the general fund for activities under the safe harbor program.

(d) **Base Level Adjustment.** The general fund base is $51,483,000 in fiscal year 2022 and $51,198,000 in fiscal year 2023.

Subd. 23. **Grant Programs; Children and Community Service Grants**	58,201,000	58,201,000
Subd. 24. **Grant Programs; Children and Economic Support Grants**	24,315,000	24,315,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2020 do not cancel but are available for this purpose in fiscal year 2021.

(b) **Shelter-Linked Youth Mental Health Grants.** $250,000 in fiscal year 2020 and $250,000 in fiscal year 2021 are from the general fund for shelter-linked youth mental health grants under Minnesota Statutes, section 256K.46.

(c) **Base Level Adjustment.** The general fund base is $22,815,000 in fiscal year 2022 and $22,815,000 in fiscal year 2023.

Subd. 25. **Grant Programs; Health Care Grants**

Appropriations by Fund		
General	3,711,000	3,711,000
Health Care Access	3,465,000	3,465,000

Subd. 26. **Grant Programs; Other Long-Term Care Grants**	1,925,000	1,925,000
Subd. 27. **Grant Programs; Aging and Adult Services Grants**	32,311,000	32,495,000

Incentive-Based Grants for Customized Living Service Providers. $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are for incentive-based grants to elderly waiver customized living service providers under article 4, section 28.

Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants**	2,886,000	2,886,000
Subd. 29. **Grant Programs; Disabilities Grants**	22,431,000	23,144,000

(a) **Training of Direct Support Services Providers.** $375,000 in fiscal year 2020 and $375,000 in fiscal year 2021 are for stipends

to pay for training of individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. This training is available to individual providers who have completed designated voluntary trainings made available through the State Service Employees International Union Healthcare Minnesota Committee. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(b) **Training for New Worker Orientation.** $125,000 in fiscal year 2020 and $125,000 in fiscal year 2021 are for new worker orientation training and is allocated to the Minnesota State Service Employees International Union Healthcare Minnesota Committee. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(c) **Benefits Planning Grants.** $600,000 in fiscal year 2020 and $600,000 in fiscal year 2021 are to provide grant funding to the Disability Hub for benefits planning to people with disabilities.

(d) **Regional Support for Person-Centered Practices Grants.** $374,000 in fiscal year

2020 and $486,000 in fiscal year 2021 are to extend and expand regional capacity for person-centered planning. This grant funding must be allocated to regional cohorts for training, coaching, and mentoring for person-centered and collaborative safety practices benefiting people with disabilities, and employees, organizations, and communities serving people with disabilities.

(e) **Disability Hub for Families Grants.** $100,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are for grants to connect families through innovation grants, life planning tools, and website information as they support a child or family member with disabilities.

(f) **Electronic Visit Verification.** $500,000 in fiscal year 2021 is for grants to providers who use a different vendor than the contract with the State of Minnesota for electronic visit verification.

(g) **Day Training and Habilitation Disability Waiver Rate System Transition Grants.** $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are from the general fund for day training and habilitation disability waiver rate system transition grants under article 5, section 90. This is a onetime appropriation.

(h) **Base Level Adjustment.** The general fund base is $22,556,000 in fiscal year 2022 and $22,168,000 in fiscal year 2023.

Subd. 30. **Grant Programs; Housing Support Grants** 9,264,000 10,364,000

Emergency Services Grants. $1,500,000 in fiscal year 2020 and $1,500,000 in fiscal year 2021 are to provide emergency services grants under Minnesota Statutes, section 256E.36. This is a onetime appropriation.

Subd. 31. **Grant Programs; Adult Mental Health Grants** 82,302,000 79,877,000

(a) **Certified Community Behavioral Health Center (CCBHC) Expansion.** $200,000 in fiscal year 2021 is from the general fund for grants for planning, staff training, and other quality improvements that are required to comply with federal CCBHC criteria for three expansion sites.

(b) **Mobile Mental Health Crisis Response Team Funding.** $1,250,000 in fiscal year 2020 and $1,250,000 in fiscal year 2021 are for adult mental health grants under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (a), clause (1), to fund regional mobile mental health crisis response teams throughout the state. The base for this appropriation is $4,896,000 in fiscal year 2022 and $4,897,000 in fiscal year 2023.

(c) **Specialized Mental Health Community Supervision Pilot Project.** $400,000 in fiscal year 2020 is for a grant to Anoka County for establishment of a specialized mental health community supervision caseload pilot project. This is a onetime appropriation.

(d) **Base Level Adjustment.** The general fund base is $83,323,000 in fiscal year 2022 and $83,324,000 in fiscal year 2023.

Subd. 32. **Grant Programs; Child Mental Health Grants** 21,826,000 21,726,000

(a) **Children's Intensive Services Reform.** $400,000 in fiscal year 2020 and $400,000 in fiscal year 2021 are for start-up grants to prospective psychiatric residential treatment facility sites for administrative expenses, consulting services, Health Insurance Portability and Accountability Act of 1996 compliance, therapeutic resources including evidence-based, culturally appropriate curriculums, and training programs for staff and clients as well as allowable physical renovations to the property.

(b) **Community-Based Children's Mental Health Grant.** Notwithstanding Minnesota Statutes, section 16B.97, $100,000 in fiscal year 2020 is for a grant to the Family Enhancement Center for staffing and administrative support to provide children access to expert mental health services regardless of a child's insurance status or income. This is a onetime appropriation and is available until June 30, 2021.

(c) **Base Level Adjustment.** The general fund base is $25,726,000 in fiscal year 2022 and $25,726,000 in fiscal year 2023.

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

Appropriations by Fund		
General	2,636,000	2,636,000
Lottery Prize	1,733,000	1,733,000

(a) **Problem Gambling.** $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are 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 related to problem gambling.

(b) **Fetal Alcohol Spectrum Disorders Grants.** (1) $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are from the general fund for a grant to Proof Alliance. Of this appropriation, Proof Alliance shall make grants to eligible regional collaboratives for the purposes specified in clause (3).

(2) "Eligible regional collaboratives" means a partnership between at least one local government and at least one community-based organization and, where available, a family home visiting program. For purposes of this clause, a local government includes a county or multicounty organization, a tribal government, a county-based purchasing entity, or a community health board.

(3) Eligible regional collaboratives must use grant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to chemically dependent women to increase positive birth outcomes.

(4) Proof Alliance must make grants to eligible regional collaboratives from both rural and urban areas of the state.

(5) An eligible regional collaborative that receives a grant under this paragraph must report to Proof Alliance by January 15 of each year on the services and programs funded by the grant. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born. Proof Alliance must compile the information in these reports and report that information to the commissioner of human services by February 15 of each year.

Subd. 34. **Direct Care and Treatment - Generally**

(a) **Transfer Authority.** Money appropriated to budget activities under this subdivision and subdivisions 35, 36, 37, and 38 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

(b) **Transfer; State-Operated Services Account.** Any balance remaining in the state operated services account at the end of fiscal year 2019, estimated to be $13,000,000 shall be transferred to the general fund.

Subd. 35. **Direct Care and Treatment - Mental Health and Substance Abuse** 129,209,000 129,201,000

(a) **Transfer Authority.** $6,438,000 in fiscal year 2020 and $6,438,000 in fiscal year 2021 are for operations of the Community Addiction

Enterprise (C.A.R.E.) program and may be transferred to the enterprise fund for C.A.R.E.

(b) **Base Level Adjustment.** The general fund base is $129,197,000 in fiscal year 2022 and $129,197,000 in fiscal year 2023.

Subd. 36. **Direct Care and Treatment - Community-Based Services**	16,630,000	17,177,000

(a) **Transfer Authority.** $2,393,000 in fiscal year 2020 and $2,393,000 in fiscal year 2021 are for operations of the Minnesota State Operated Community Services (MSOCS) program and may be transferred to the enterprise fund for MSOCS.

(b) **MSOCS Operating Adjustment.** $1,594,000 in fiscal year 2020 and $3,729,000 in fiscal year 2021 are from the general fund for the Minnesota State Operated Community Services program. The commissioner shall transfer $1,594,000 in fiscal year 2020 and $3,729,000 in fiscal year 2021 to the enterprise fund for MSOCS.

(c) **Base Level Adjustment.** The general fund base is $17,176,000 in fiscal year 2022 and $17,176,000 in fiscal year 2023.

Subd. 37. **Direct Care and Treatment - Forensic Services**	112,126,000	115,342,000

Base Level Adjustment. The general fund base is $115,944,000 in fiscal year 2022 and $115,944,000 in fiscal year 2023.

Subd. 38. **Direct Care and Treatment - Sex Offender Program**	97,072,000	97,621,000

(a) **Transfer Authority.** Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the

biennium with the approval of the commissioner of management and budget.

(b) **Base Level Adjustment.** The general fund base is $98,166,000 in fiscal year 2022 and $98,166,000 in fiscal year 2023.

Subd. 39. **Direct Care and Treatment - Operations**	47,398,000	47,657,000

Base Level Adjustment. The general fund base is $47,656,000 in fiscal year 2022 and $47,656,000 in fiscal year 2023.

Subd. 40. **Technical Activities**	75,884,000	82,316,000

(a) **Generally.** This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund base is $79,198,000 in fiscal year 2022 and $78,254,000 in fiscal year 2023.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$ 231,829,000**	**$ 236,188,000**

Appropriations by Fund

	2020	2021
General	124,381,000	126,276,000
State Government Special Revenue	58,450,000	61,367,000
Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	94,980,000	96,117,000
State Government Special Revenue	7,614,000	7,558,000

Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2020 and $3,579,000 in fiscal year 2021 are from the TANF fund for home visiting and nutritional services under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2020 and $2,000,000 in fiscal year 2021 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2020 and $4,978,000 in fiscal year 2021 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2020 and $1,156,000 in fiscal year 2021 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(5) The commissioner may use up to 6.23 percent of the amounts appropriated from the TANF fund each year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) **Comprehensive Suicide Prevention.** $2,730,000 in fiscal year 2020 and $2,730,000 in fiscal year 2021 are from the general fund for a comprehensive, community-based suicide prevention strategy. The funds are allocated as follows:

(1) $955,000 in fiscal year 2020 and $955,000 in fiscal year 2021 are for community-based suicide prevention grants authorized in Minnesota Statutes, section 145.56, subdivision 2. Specific emphasis must be placed on those communities with the greatest disparities. The base for this appropriation is $1,291,000 in fiscal year 2022 and $1,291,000 in fiscal year 2023;

(2) $683,000 in fiscal year 2020 and $683,000 in fiscal year 2021 are to support evidence-based training for educators and school staff and purchase suicide prevention curriculum for student use statewide, as authorized in Minnesota Statutes, section 145.56, subdivision 2. The base for this

appropriation is $913,000 in fiscal year 2022 and $913,000 in fiscal year 2023;

(3) $137,000 in fiscal year 2020 and $137,000 in fiscal year 2021 are to implement the Zero Suicide framework with up to 20 behavioral and health care organizations each year to treat individuals at risk for suicide and support those individuals across systems of care upon discharge. The base for this appropriation is $205,000 in fiscal year 2022 and $205,000 in fiscal year 2023;

(4) $955,000 in fiscal year 2020 and $955,000 in fiscal year 2021 are to develop and fund a Minnesota-based network of National Suicide Prevention Lifeline, providing statewide coverage. The base for this appropriation is $1,321,000 in fiscal year 2022 and $1,321,000 in fiscal year 2023; and

(5) the commissioner may retain up to 18.23 percent of the appropriation under this paragraph to administer the comprehensive suicide prevention strategy.

(d) **Statewide Tobacco Cessation.** $1,598,000 in fiscal year 2020 and $2,748,000 in fiscal year 2021 are from the general fund for statewide tobacco cessation services under Minnesota Statutes, section 144.397. The base for this appropriation is $2,878,000 in fiscal year 2022 and $2,878,000 in fiscal year 2023.

(e) **Health Care Access Survey.** $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are from the health care access fund to continue and improve the Minnesota Health

Care Access Survey. These appropriations may be used in either year of the biennium.

(f) **Community Solutions for Healthy Child Development Grant Program.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for the community solutions for healthy child development grant program to promote health and racial equity for young children and their families under Minnesota Statutes, section 145.9285. The commissioner may use up to 23.5 percent of the total appropriation for administration. The base for this appropriation is $1,000,000 in fiscal year 2022, $1,000,000 in fiscal year 2023, and $0 in fiscal year 2024.

(g) **Domestic Violence and Sexual Assault Prevention Program.** $375,000 in fiscal year 2020 and $375,000 in fiscal year 2021 are from the general fund for the domestic violence and sexual assault prevention program under Minnesota Statutes, section 145.987. This is a onetime appropriation.

(h) **Skin Lightening Products Public Awareness Grant Program.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are from the general fund for a skin lightening products public awareness and education grant program. This is a onetime appropriation.

(i) **Cannabinoid Products Workgroup.** $8,000 in fiscal year 2020 is from the state government special revenue fund for the cannabinoid products workgroup. This is a onetime appropriation.

(j) **Base Level Adjustments.** The general fund base is $96,742,000 in fiscal year 2022 and $96,742,000 in fiscal year 2023. The health care access fund base is $37,432,000 in fiscal year 2022 and $36,832,000 in fiscal year 2023.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	18,803,000	19,774,000
State Government Special Revenue	50,836,000	53,809,000

(a) **Public Health Laboratory Equipment.** $840,000 in fiscal year 2020 and $655,000 in fiscal year 2021 are from the general fund for equipment for the public health laboratory. This is a onetime appropriation and is available until June 30, 2023.

(b) **Base Level Adjustment.** The general fund base is $19,119,000 in fiscal year 2022 and $19,119,000 in fiscal year 2023. The state government special revenue fund base is $53,782,000 in fiscal year 2022 and $53,782,000 in fiscal year 2023.

Subd. 4. **Health Operations** 10,598,000 10,385,000

Base Level Adjustment. The general fund base is $10,912,000 in fiscal year 2022 and $10,912,000 in fiscal year 2023.

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 27,203,000 $ 26,597,000**

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	629,000	641,000
Subd. 3. **Board of Dentistry**	1,503,000	1,450,000
Emeritus Licensing Activities. $8,000 in fiscal year 2020 and $5,000 in fiscal year 2021 are for emeritus licensing activities under Minnesota Statutes, section 150A.06.		
Subd. 4. **Board of Dietetics and Nutrition Practice**	147,000	149,000
Subd. 5. **Board of Marriage and Family Therapy**	384,000	389,000
Base Level Adjustment. The base is $384,000 in fiscal year 2022 and $384,000 in fiscal year 2023.		
Subd. 6. **Board of Medical Practice**	6,013,000	5,996,000
(a) **Health Professional Services Program.** This appropriation includes $1,023,000 in fiscal year 2020 and $1,002,000 in fiscal year 2021 for the health professional services program.		
(b) **Base Level Adjustment.** The base is $5,912,000 in fiscal year 2022 and $5,868,000 in fiscal year 2023.		
Subd. 7. **Board of Nursing**	4,993,000	4,993,000
Subd. 8. **Board of Nursing Home Administrators**	3,733,000	3,201,000
(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $3,445,000 in fiscal year 2020 and $2,910,000 in fiscal year 2021 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.		
(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this		

appropriation, $150,000 in fiscal year 2020 and $150,000 in fiscal year 2021 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $558,000 in fiscal year 2020 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. These funds are available either year of the biennium.

(d) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of appropriations currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management

and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 9. **Board of Optometry**	222,000	223,000
Subd. 10. **Board of Pharmacy**	4,307,000	4,341,000

Base Level Adjustment. The base is $4,338,000 in fiscal year 2022 and $4,338,000 in fiscal year 2023.

Subd. 11. **Board of Physical Therapy**	547,000	549,000
Subd. 12. **Board of Podiatric Medicine**	199,000	199,000
Subd. 13. **Board of Psychology**	1,357,000	1,395,000

Base Level Adjustment. The base is $1,355,000 in fiscal year 2022 and $1,355,000 in fiscal year 2023.

Subd. 14. **Board of Social Work**	1,437,000	1,404,000
Subd. 15. **Board of Veterinary Medicine**	345,000	353,000
Subd. 16. **Board of Behavioral Health and Therapy**	937,000	858,000

Base Level Adjustment. The base is $833,000 in fiscal year 2022 and $833,000 in fiscal year 2023.

Subd. 17. **Board of Occupational Therapy Practice**	450,000	456,000
Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$ 3,747,000**	**$ 3,809,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2020 and $950,000 in fiscal year 2021 are for the

Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2020 and $861,000 in fiscal year 2021 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2020 and $89,000 in fiscal year 2021 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $1,851,000 in fiscal year 2020 and $1,913,000 in fiscal year 2021 are for board operations. The base for this program is $1,880,000 in fiscal year 2022 and $1,880,000 in fiscal year 2023.

(c) **Regional Grants.** $585,000 in fiscal year 2020 and $585,000 in fiscal year 2021 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grant.** $585,000 in fiscal year 2020 and $585,000 in fiscal year 2021 are for training grants under Minnesota Statutes, section 144E.35.

(e) **Base Level Adjustment.** The base is $3,776,000 in fiscal year 2022 and $3,776,000 in fiscal year 2023.

Sec. 6. **COUNCIL ON DISABILITY** **$ 1,014,000 $ 1,006,000**

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,438,000 $ 2,438,000**

Department of Psychiatry Monitoring. $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 714,000 $ 723,000**

Sec. 9. **COMMISSIONER OF COMMERCE** **$ 27,000 $ 27,000**

Sec. 10. **BOARD OF DIRECTORS OF MNSURE** **$ 8,000,000 $ 0**

This appropriation shall be transferred to the MNsure enterprise fund.

Sec. 11. **COMMISSIONER OF MANAGEMENT AND BUDGET** **$ 498,000 $ 498,000**

(a) **Proven-Effective Practices Evaluation Activities.** $498,000 in fiscal year 2020 and $498,000 in fiscal year 2021 are from the general fund for evaluation activities under Minnesota Statutes, section 16A.055, subdivision 1a.

(b) **Transfer; Premium Security Account.** By August 30, 2020, the commissioner of commerce shall transfer $142,000,000 from the premium security account to the general fund. This is a onetime transfer.

(c) **Transfer Cancellation.** The commissioner of management and budget shall not make the $50,000,000 transfer authorized under Minnesota Statutes, section 62U.10, subdivision 8, in fiscal year 2019 resulting from the December 2017 report conducted under Minnesota Statutes, section 62U.10, subdivision 7.

(d) **Savings Determination.** (1) When preparing the forecast for state revenues and

expenditures under Minnesota Statutes, section 16A.103, the commissioner of management and budget shall assume a reduction of health and human services spending of $100,000,000 for the biennium beginning July 1, 2022, until the end of the legislative session that enacts a budget for the Department of Health and the Department of Human Services for that biennium.

(2) Upon enactment of a budget for the Department of Health and the Department of Human Services for the biennium beginning July 1, 2022, the legislature shall identify enacted provisions that were recommended by or based on the recommendation of the Blue Ribbon Commission on Health and Human Services.

(3) To the extent the net savings attributable to the provisions in clause (2) for the biennium beginning July 1, 2022, are less than $100,000,000, the commissioner shall reduce the balance of the general fund budget reserve established under Minnesota Statutes, section 16A.152, subdivision 1a, by an amount equal to the difference between the savings identified in clause (2) and the assumed $100,000,000 of savings in clause (1).

Sec. 12. **TRANSFERS.**

Subdivision 1. **Forecasted programs.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2021, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, housing support, the entitlement portion of Northstar Care for Children under Minnesota Statutes,

chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Committee and the house of representatives Health and Human Services Finance Division quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Committee and the house of representatives Health and Human Services Finance Division quarterly about transfers made under this subdivision.

Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2021, unless a different expiration date is explicit.

Sec. 15. **EFFECTIVE DATE.**

This article is effective July 1, 2019, unless a different effective date is specified.

119B.125 PROVIDER REQUIREMENTS.

Subd. 8. **Overpayment claim for failure to comply with access to records requirement.** (a) In establishing an overpayment claim under subdivision 6 for failure to provide access to attendance records, the county or commissioner is limited to the six years prior to the date the county or the commissioner requested the attendance records.

(b) When the commissioner or county establishes an overpayment claim against a current or former provider, the commissioner or county must provide notice of the claim to the provider. A notice of overpayment claim must specify the reason for the overpayment, the authority for making the overpayment claim, the time period in which the overpayment occurred, the amount of the overpayment, and the provider's right to appeal.

(c) The commissioner or county may seek to recover overpayments paid to a current or former provider. When a provider has been convicted of fraud under section 256.98, theft under section 609.52, or a federal crime relating to theft of state funds or fraudulent billing for a program administered by the commissioner or a county, recovery may be sought regardless of the amount of overpayment.

119B.16 FAIR HEARING PROCESS.

Subd. 2. **Informal conference.** The county agency shall offer an informal conference to applicants and recipients adversely affected by an agency action to attempt to resolve the dispute. The county agency shall offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. The county agency or the provider may ask the family in whose case the overpayment arose to participate in the informal conference, but the family may refuse to do so. The county agency shall advise adversely affected applicants, recipients, and providers that a request for a conference with the agency is optional and does not delay or replace the right to a fair hearing.

144.414 PROHIBITIONS.

Subd. 5. **Electronic cigarettes.** (a) The use of electronic cigarettes, including the inhaling or exhaling of vapor from any electronic delivery device, as defined in section 609.685, subdivision 1, is prohibited in the following locations:

(1) any building owned or operated by the state, home rule charter or statutory city, county, township, school district, or other political subdivision;

(2) any facility owned by Minnesota State Colleges and Universities and the University of Minnesota;

(3) any facility licensed by the commissioner of human services; or

(4) any facility licensed by the commissioner of health, but only if the facility is also subject to federal licensing requirements.

(b) Nothing in this subdivision shall prohibit political subdivisions or businesses from adopting more stringent prohibitions on the use of electronic cigarettes or electronic delivery devices.

144A.45 REGULATION OF HOME CARE SERVICES.

Subd. 6. **Home care providers; tuberculosis prevention and control.** (a) A home care provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the home care provider.

144A.481 HOME CARE LICENSING IMPLEMENTATION FOR NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.

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

(b) Temporary home care licenses issued beginning January 1, 2014, shall be issued according to sections 144A.43 to 144A.4798, and the fees in section 144A.472. Temporary licensees must comply with the requirements of this chapter.

(c) No temporary license applications will be accepted nor temporary licenses issued between December 1, 2013, and December 31, 2013.

(d) Beginning October 1, 2013, changes in ownership applications will require payment of the new fees listed in section 144A.472. Providers who are providing nursing, delegated nursing, or professional health care services, must submit the fee for comprehensive home care providers, and all other providers must submit the fee for basic home care providers as provided in section 144A.472. Change of ownership applicants will be issued a new home care license based on the licensure law in effect on June 30, 2013.

Subd. 2. **Current home care licensees with licenses as of December 31, 2013.** (a) Beginning July 1, 2014, department licensed home care providers must apply for either the basic or comprehensive home care license on their regularly scheduled renewal date.

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

Subd. 3. **Renewal application of home care licensure during transition period.** (a) Renewal and change of ownership applications of home care licenses issued beginning July 1, 2014, will be issued according to sections 144A.43 to 144A.4798 and, upon license renewal or issuance of a new license for a change of ownership, providers must comply with sections 144A.43 to 144A.4798. Prior to renewal, providers must comply with the home care licensure law in effect on June 30, 2013.

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

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

151.42 CITATION.

Sections 151.42 to 151.51 may be cited as the "Wholesale Drug Distribution Licensing Act of 1990."

151.44 DEFINITIONS.

As used in sections 151.43 to 151.51, the following terms have the meanings given in paragraphs (a) to (h):

(a) "Wholesale drug distribution" means distribution of prescription or nonprescription drugs to persons other than a consumer or patient or reverse distribution of such drugs, but does not include:

(1) a sale between a division, subsidiary, parent, affiliated, or related company under the common ownership and control of a corporate entity;

(2) the purchase or other acquisition, by a hospital or other health care entity that is a member of a group purchasing organization, of a drug for its own use from the organization or from other hospitals or health care entities that are members of such organizations;

(3) the sale, purchase, or trade of a drug or an offer to sell, purchase, or trade a drug by a charitable organization described in section 501(c)(3) of the Internal Revenue Code of 1986, as amended through December 31, 1988, to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

(4) the sale, purchase, or trade of a drug or offer to sell, purchase, or trade a drug among hospitals or other health care entities that are under common control;

(5) the sale, purchase, or trade of a drug or offer to sell, purchase, or trade a drug for emergency medical reasons;

(6) the sale, purchase, or trade of a drug, an offer to sell, purchase, or trade a drug, or the dispensing of a drug pursuant to a prescription;

(7) the transfer of prescription or nonprescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage;

(8) the distribution of prescription or nonprescription drug samples by manufacturers representatives; or

(9) the sale, purchase, or trade of blood and blood components.

(b) "Wholesale drug distributor" means anyone engaged in wholesale drug distribution including, but not limited to, manufacturers; repackagers; own-label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and pharmacies that conduct wholesale drug distribution. A wholesale drug distributor does not include a common carrier or individual hired primarily to transport prescription or nonprescription drugs.

(c) "Manufacturer" has the meaning provided in section 151.01, subdivision 14a.

(d) "Prescription drug" means a drug required by federal or state law or regulation to be dispensed only by a prescription, including finished dosage forms and active ingredients subject to United States Code, title 21, sections 811 and 812.

(e) "Blood" means whole blood collected from a single donor and processed either for transfusion or further manufacturing.

(f) "Blood components" means that part of blood separated by physical or mechanical means.

(g) "Reverse distribution" means the receipt of prescription or nonprescription drugs received from or shipped to Minnesota locations for the purpose of returning the drugs to their producers or distributors.

(h) "Reverse distributor" means a person engaged in the reverse distribution of drugs.

151.49 LICENSE RENEWAL APPLICATION PROCEDURES.

Application blanks or notices for renewal of a license required by sections 151.42 to 151.51 shall be mailed or otherwise provided to each licensee on or before the first day of the month prior to the month in which the license expires and, if application for renewal of the license with the required fee and supporting documents is not made before the expiration date, the existing license or renewal shall lapse and become null and void upon the date of expiration.

151.50 RULES.

The board shall adopt rules to carry out the purposes and enforce the provisions of sections 151.42 to 151.51. All rules adopted under this section shall conform to wholesale drug distributor licensing guidelines formally adopted by the United States Food and Drug Administration; and in case of conflict between a rule adopted by the board and a Food and Drug Administration wholesale drug distributor guideline, the latter shall control.

151.51 BOARD ACCESS TO WHOLESALE DRUG DISTRIBUTOR RECORDS.

Wholesale drug distributors may keep records at a central location apart from the principal office of the wholesale drug distributor or the location at which the drugs were stored and from which they were shipped, provided that the records shall be made available for inspection within two working days of a request by the board. The records may be kept in any form permissible under federal law applicable to prescription drugs record keeping.

151.55 CANCER DRUG REPOSITORY PROGRAM.

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

(b) "Board" means the Board of Pharmacy.

(c) "Cancer drug" means a prescription drug that is used to treat:

(1) cancer or the side effects of cancer; or

(2) the side effects of any prescription drug that is used to treat cancer or the side effects of cancer.

(d) "Cancer drug repository" means a medical facility or pharmacy that has notified the board of its election to participate in the cancer drug repository program.

(e) "Cancer supply" or "supplies" means prescription and nonprescription cancer supplies needed to administer a cancer drug.

(f) "Dispense" has the meaning given in section 151.01, subdivision 30.

(g) "Distribute" means to deliver, other than by administering or dispensing.

(h) "Donor" means an individual and not a drug manufacturer or wholesale drug distributor who donates a cancer drug or supply according to the requirements of the cancer drug repository program.

(i) "Medical facility" means an institution defined in section 144.50, subdivision 2.

(j) "Medical supplies" means any prescription and nonprescription medical supply needed to administer a cancer drug.

(k) "Pharmacist" has the meaning given in section 151.01, subdivision 3.

(l) "Pharmacy" means any pharmacy registered with the Board of Pharmacy according to section 151.19, subdivision 1.

(m) "Practitioner" has the meaning given in section 151.01, subdivision 23.

(n) "Prescription drug" means a legend drug as defined in section 151.01, subdivision 17.

(o) "Side effects of cancer" means symptoms of cancer.

(p) "Single-unit-dose packaging" means a single-unit container for articles intended for administration as a single dose, direct from the container.

(q) "Tamper-evident unit dose packaging" means a container within which a drug is sealed so that the contents cannot be opened without obvious destruction of the seal.

Subd. 2. **Establishment.** The Board of Pharmacy shall establish and maintain a cancer drug repository program, under which any person may donate a cancer drug or supply for use by an individual who meets the eligibility criteria specified under subdivision 4. Under the program, donations may be made on the premises of a medical facility or pharmacy that elects to participate in the program and meets the requirements specified under subdivision 3.

Subd. 3. **Requirements for participation by pharmacies and medical facilities.** (a) To be eligible for participation in the cancer drug repository program, a pharmacy or medical facility must be licensed and in compliance with all applicable federal and state laws and administrative rules.

(b) Participation in the cancer drug repository program is voluntary. A pharmacy or medical facility may elect to participate in the cancer drug repository program by submitting the following information to the board, in a form provided by the board:

(1) the name, street address, and telephone number of the pharmacy or medical facility;

(2) the name and telephone number of a pharmacist who is employed by or under contract with the pharmacy or medical facility, or other contact person who is familiar with the pharmacy's or medical facility's participation in the cancer drug repository program; and

(3) a statement indicating that the pharmacy or medical facility meets the eligibility requirements under paragraph (a) and the chosen level of participation under paragraph (c).

(c) A pharmacy or medical facility may fully participate in the cancer drug repository program by accepting, storing, and dispensing or administering donated drugs and supplies, or may limit its participation to only accepting and storing donated drugs and supplies. If a pharmacy or facility chooses to limit its participation, the pharmacy or facility shall distribute any donated drugs to a fully participating cancer drug repository according to subdivision 8.

(d) A pharmacy or medical facility may withdraw from participation in the cancer drug repository program at any time upon notification to the board. A notice to withdraw from participation may be given by telephone or regular mail.

Subd. 4. **Individual eligibility requirements.** Any Minnesota resident who is diagnosed with cancer is eligible to receive drugs or supplies under the cancer drug repository program. Drugs and supplies shall be dispensed or administered according to the priority given under subdivision 6, paragraph (d).

Subd. 5. **Donations of cancer drugs and supplies.** (a) Any one of the following persons may donate legally obtained cancer drugs or supplies to a cancer drug repository, if the drugs or supplies meet the requirements under paragraph (b) or (c) as determined by a pharmacist who is employed by or under contract with a cancer drug repository:

(1) an individual who is 18 years old or older; or

(2) a pharmacy, medical facility, drug manufacturer, or wholesale drug distributor, if the donated drugs have not been previously dispensed.

(b) A cancer drug is eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative;

(2) the drug's expiration date is at least six months later than the date that the drug was donated;

(3) the drug is in its original, unopened, tamper-evident unit dose packaging that includes the drug's lot number and expiration date. Single-unit dose drugs may be accepted if the single-unit-dose packaging is unopened; and

(4) the drug is not adulterated or misbranded.

(c) Cancer supplies are eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the supplies are not adulterated or misbranded;

(2) the supplies are in their original, unopened, sealed packaging; and

(3) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative.

(d) The cancer drug repository donor form must be provided by the board and shall state that to the best of the donor's knowledge the donated drug or supply has been properly stored and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded. The board shall make the cancer drug repository donor form available on the Board of Pharmacy's website.

(e) Controlled substances and drugs and supplies that do not meet the criteria under this subdivision are not eligible for donation or acceptance under the cancer drug repository program.

(f) Drugs and supplies may be donated on the premises of a cancer drug repository to a pharmacist designated by the repository. A drop box may not be used to deliver or accept donations.

(g) Cancer drugs and supplies donated under the cancer drug repository program must be stored in a secure storage area under environmental conditions appropriate for the drugs or supplies being stored. Donated drugs and supplies may not be stored with nondonated inventory.

Subd. 6. **Dispensing requirements.** (a) Drugs and supplies must be dispensed by a licensed pharmacist pursuant to a prescription by a practitioner or may be dispensed or administered by a practitioner according to the requirements of this chapter and within the practitioner's scope of practice.

(b) Cancer drugs and supplies shall be visually inspected by the pharmacist or practitioner before being dispensed or administered for adulteration, misbranding, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way may not be dispensed or administered.

(c) Before a cancer drug or supply may be dispensed or administered to an individual, the individual must sign a cancer drug repository recipient form provided by the board acknowledging that the individual understands the information stated on the form. The form shall include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the cancer drug repository, the Board of Pharmacy, and any other participant of the cancer drug repository program cannot guarantee the safety of the drug or supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

The board shall make the cancer drug repository form available on the Board of Pharmacy's website.

(d) Drugs and supplies shall only be dispensed or administered to individuals who meet the eligibility requirements in subdivision 4 and in the following order of priority:

(1) individuals who are uninsured;

(2) individuals who are enrolled in medical assistance, MinnesotaCare, Medicare, or other public assistance health care; and

(3) all other individuals who are otherwise eligible under subdivision 4 to receive drugs or supplies from a cancer drug repository.

Subd. 7. **Handling fees.** A cancer drug repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each cancer drug or supply dispensed or administered.

Subd. 8. **Distribution of donated cancer drugs and supplies.** (a) Cancer drug repositories may distribute drugs and supplies donated under the cancer drug repository program to other repositories if requested by a participating repository.

(b) A cancer drug repository that has elected not to dispense donated drugs or supplies shall distribute any donated drugs and supplies to a participating repository upon request of the repository.

(c) If a cancer drug repository distributes drugs or supplies under paragraph (a) or (b), the repository shall complete a cancer drug repository donor form provided by the board. The completed form and a copy of the donor form that was completed by the original donor under subdivision 5 shall be provided to the fully participating cancer drug repository at the time of distribution.

Subd. 9. **Resale of donated drugs or supplies.** Donated drugs and supplies may not be resold.

Subd. 10. **Record-keeping requirements.** (a) Cancer drug repository donor and recipient forms shall be maintained for at least five years.

(b) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 6 shall be maintained by the dispensing repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the cancer drug destroyed;

(3) the name of the person or firm that destroyed the drug; and

(4) the source of the drugs or supplies destroyed.

Subd. 11. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A medical facility or pharmacy participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a cancer drug or supply as defined in subdivision 1 is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom

the cancer drug or supply is dispensed and no disciplinary action shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the cancer drug or supply.

214.17 HIV, HBV, AND HCV PREVENTION PROGRAM; PURPOSE AND SCOPE.

Sections 214.17 to 214.25 are intended to promote the health and safety of patients and regulated persons by reducing the risk of infection in the provision of health care.

214.18 DEFINITIONS.

Subdivision 1. **Board.** "Board" means the Boards of Dentistry, Medical Practice, Nursing, and Podiatric Medicine. For purposes of sections 214.19, subdivisions 4 and 5; 214.20, paragraph (1); and 214.24, board also includes the Board of Chiropractic Examiners.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **HBV.** "HBV" means the hepatitis B virus with the e antigen present in the most recent blood test.

Subd. 3a. **HCV.** "HCV" means the hepatitis C virus.

Subd. 4. **HIV.** "HIV" means the human immunodeficiency virus.

Subd. 5. **Regulated person.** "Regulated person" means a licensed dental hygienist, dentist, physician, nurse who is currently registered as a registered nurse or licensed practical nurse, podiatrist, a registered dental assistant, a physician assistant, and for purposes of sections 214.19, subdivisions 4 and 5; 214.20, paragraph (a); and 214.24, a chiropractor.

214.19 REPORTING OBLIGATIONS.

Subdivision 1. **Permission to report.** A person with actual knowledge that a regulated person has been diagnosed as infected with HIV, HBV, or HCV may file a report with the commissioner.

Subd. 2. **Self-reporting.** A regulated person who is diagnosed as infected with HIV, HBV, or HCV shall report that information to the commissioner promptly, and as soon as medically necessary for disease control purposes but no more than 30 days after learning of the diagnosis or 30 days after becoming licensed or registered by the state.

Subd. 3. **Mandatory reporting.** A person or institution required to report HIV, HBV, or HCV status to the commissioner under Minnesota Rules, parts 4605.7030, subparts 1 to 4 and 6, and 4605.7040, shall, at the same time, notify the commissioner if the person or institution knows that the reported person is a regulated person.

Subd. 4. **Infection control reporting.** A regulated person shall, within ten days, report to the appropriate board personal knowledge of a serious failure or a pattern of failure by another regulated person to comply with accepted and prevailing infection control procedures related to the prevention of HIV, HBV, and HCV transmission. In lieu of reporting to the board, the regulated person may make the report to a designated official of the hospital, nursing home, clinic, or other institution or agency where the failure to comply with accepted and prevailing infection control procedures occurred. The designated official shall report to the appropriate board within 30 days of receiving a report under this subdivision. The report shall include specific information about the response by the institution or agency to the report. A regulated person shall not be discharged or discriminated against for filing a complaint in good faith under this subdivision.

Subd. 5. **Immunity.** A person is immune from civil liability or criminal prosecution for submitting a report in good faith to the commissioner or to a board under this section.

214.20 GROUNDS FOR DISCIPLINARY OR RESTRICTIVE ACTION.

A board may refuse to grant a license or registration or may impose disciplinary or restrictive action against a regulated person who:

(1) fails to follow accepted and prevailing infection control procedures, including a failure to conform to current recommendations of the Centers for Disease Control for preventing the transmission of HIV, HBV, and HCV, or fails to comply with infection control rules promulgated by the board. Injury to a patient need not be established;

(2) fails to comply with any requirement of sections 214.17 to 214.24; or

(3) fails to comply with any monitoring or reporting requirement.

214.21 TEMPORARY SUSPENSION.

The board may, without hearing, temporarily suspend the right to practice of a regulated person if the board finds that the regulated person has refused to submit to or comply with monitoring under section 214.23. The suspension shall take effect upon written notice to the regulated person specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order based on a stipulation or after a hearing. At the time the board issues the suspension notice, the board shall schedule a disciplinary hearing to be held under chapter 14. The regulated person shall be provided with at least 20 days' notice of a hearing held under this section. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

214.22 NOTICE; ACTION.

If the board has reasonable grounds to believe a regulated person infected with HIV, HBV, or HCV has done or omitted doing any act that would be grounds for disciplinary action under section 214.20, the board may take action after giving notice three business days before the action, or a lesser time if deemed necessary by the board. The board may:

(1) temporarily suspend the regulated person's right to practice under section 214.21;

(2) require the regulated person to appear personally at a conference with representatives of the board and to provide information relating to the regulated person's health or professional practice; and

(3) take any other lesser action deemed necessary by the board for the protection of the public.

214.23 MONITORING.

Subdivision 1. **Commissioner of health.** The board shall enter into a contract with the commissioner to perform the functions in subdivisions 2 and 3. The contract shall provide that:

(1) unless requested to do otherwise by a regulated person, a board shall refer all regulated persons infected with HIV, HBV, or HCV to the commissioner;

(2) the commissioner may choose to refer any regulated person who is infected with HIV, HBV, or HCV as well as all information related thereto to the person's board at any time for any reason, including but not limited to: the degree of cooperation and compliance by the regulated person; the inability to secure information or the medical records of the regulated person; or when the facts may present other possible violations of the regulated persons practices act. Upon request of the regulated person who is infected with HIV, HBV, or HCV the commissioner shall refer the regulated person and all information related thereto to the person's board. Once the commissioner has referred a regulated person to a board, the board may not thereafter submit it to the commissioner to establish a monitoring plan unless the commissioner of health consents in writing;

(3) a board shall not take action on grounds relating solely to the HIV, HBV, or HCV status of a regulated person until after referral by the commissioner; and

(4) notwithstanding sections 13.39 and 13.41 and chapters 147, 147A, 148, 150A, 153, and 214, a board shall forward to the commissioner any information on a regulated person who is infected with HIV, HBV, or HCV that the Department of Health requests.

Subd. 2. **Monitoring plan.** After receiving a report that a regulated person is infected with HIV, HBV, or HCV, the board or the commissioner acting on behalf of the board shall evaluate the past and current professional practice of the regulated person to determine whether there has been a violation under section 214.20. After evaluation of the regulated person's past and current professional practice, the board or the commissioner, acting on behalf of the board, shall establish a monitoring plan for the regulated person. The monitoring plan may:

(1) address the scope of a regulated person's professional practice when the board or the commissioner, acting on behalf of the board, determines that the practice constitutes an identifiable risk of transmission of HIV, HBV, or HCV from the regulated person to the patient;

(2) include the submission of regular reports at a frequency determined by the board or the commissioner, acting on behalf of the board, regarding the regulated person's health status; and

(3) include any other provisions deemed reasonable by the board or the commissioner of health, acting on behalf of the board.

The board or commissioner, acting on behalf of the board, may enter into agreements with qualified persons to perform monitoring on its behalf. The regulated person shall comply with any monitoring plan established under this subdivision.

Subd. 3. **Expert review panel.** The board or the commissioner acting on behalf of the board may appoint an expert review panel to assist in the performance of the responsibilities under this section. In consultations with the expert review panel, the commissioner or board shall, to the extent possible, protect the identity of the regulated person. When an expert review panel is appointed, it must contain at least one member appointed by the commissioner and one professional member appointed by the board. The panel shall provide expert assistance to the board, or to the commissioner acting on behalf of the board, in the subjects of infectious diseases, epidemiology, practice techniques used by regulated persons, and other subjects determined by the board or by the commissioner acting on behalf of the board. Members of the expert review panel are subject to those provisions of chapter 13 that restrict the commissioner or the board under Laws 1992, chapter 559, article 1.

Subd. 4. **Immunity.** Members of the board or the commissioner acting on behalf of the board, and persons who participate on an expert review panel or who assist the board or the commissioner in monitoring the practice of a regulated person, are immune from civil liability or criminal prosecution for any actions, transactions, or publications made in good faith and in execution of, or relating to, their duties under sections 214.17 to 214.24, except that no immunity shall be available for persons who have knowingly violated any provision of chapter 13.

214.24 INSPECTION OF PRACTICE.

Subdivision 1. **Authority.** The board is authorized to conduct inspections of the clinical practice of a regulated person to determine whether the regulated person is following accepted and prevailing infection control procedures. The board shall provide at least three business days' notice to the clinical practice prior to the inspection. The clinical practice of a regulated person includes any location where the regulated person practices that is not an institution licensed and subject to inspection by the commissioner of health. During the course of inspections the privacy and confidentiality of patients and regulated persons shall be maintained. The board may require on license renewal forms that regulated persons inform the board of all locations where they practice.

Subd. 2. **Access; records.** An inspector from the board shall have access, during reasonable business hours for purposes of inspection, to all areas of the practice setting where patient care is rendered or drugs or instruments are held that come into contact with a patient. An inspector is authorized to interview employees and regulated persons in the performance of an inspection, to observe infection control procedures, test equipment used to sterilize instruments, and to review and copy all relevant records, excluding patient health records. In performing these responsibilities, inspectors shall make reasonable efforts to respect and preserve patient privacy and the privacy of the regulated person. Boards are authorized to conduct joint inspections and to share information obtained under this section. The boards shall contract with the commissioner to perform the duties under this subdivision.

Subd. 3. **Board action.** If accepted and prevailing infection control techniques are not being followed, the board may educate the regulated person or take other actions. The board and the inspector shall maintain patient confidentiality in any action resulting from the inspection.

Subd. 4. **Rulemaking.** A board is authorized to adopt rules setting standards for infection control procedures. Boards shall engage in joint rulemaking. Boards must seek and consider the advice of the commissioner of health before adopting rules. No inspections shall be conducted under this section until after infection control rules have been adopted. Each board is authorized to provide educational information and training to regulated persons regarding infection control. All regulated persons who are employers shall make infection control rules available to employees who engage in functions related to infection control.

245E.06 ADMINISTRATIVE SANCTIONS.

Subd. 2. **Written notice of department sanction; sanction effective date; informal meeting.** (a) The department shall give notice in writing to a person of an administrative sanction that is to be imposed. The notice shall be sent by mail as defined in section 245E.01, subdivision 11.

(b) The notice shall state:

(1) the factual basis for the department's determination;

(2) the sanction the department intends to take;

(3) the dollar amount of the monetary recovery or recoupment, if any;

(4) how the dollar amount was computed;

(5) the right to dispute the department's determination and to provide evidence;

(6) the right to appeal the department's proposed sanction; and

(7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.

(c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:

(1) the length of the denial or termination;

(2) the requirements and procedures for reinstatement; and

(3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.

(d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.

(e) Notwithstanding section 245E.03, subdivision 4, the effective date of the proposed sanction shall be 30 days after the license holder's, provider's, controlling individual's, or recipient's receipt of the notice, unless timely appealed. If a timely appeal is made, the proposed sanction shall be delayed pending the final outcome of the appeal. Implementation of a proposed sanction following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of sanction is necessary to protect the health or safety of children in care. The department may consider the economic hardship of a person in implementing the proposed sanction, but economic hardship shall not be a determinative factor in implementing the proposed sanction.

(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals must be sent or delivered to the department's Office of Inspector General, Financial Fraud and Abuse Division.

Subd. 4. **Consolidated hearings with licensing sanction.** If a financial misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing sanction exists for which there is an appeal hearing right and the sanction is timely appealed, and the overpayment recovery action and licensing sanction involve the same set of facts, the overpayment recovery action and licensing sanction must be consolidated in the contested case hearing related to the licensing sanction.

Subd. 5. **Effect of department's administrative determination or sanction.** Unless a timely and proper appeal is received by the department, the department's administrative determination or sanction shall be considered a final department determination.

245H.10 BACKGROUND STUDIES.

Subd. 2. **Direct contact.** (a) The subject of the background study may not provide direct contact services to a child served by a certified center unless the subject is under continuous direct supervision pending completion of the background study.

(b) The certified center must document in the staff person's personnel file the date the program initiates a background study and the date the subject of the study first had direct contact with a child served by the center.

246.18 DISPOSAL OF FUNDS.

Subd. 8. **State-operated services account.** (a) The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

(1) intensive residential treatment services;

(2) foster care services; and

(3) psychiatric extensive recovery treatment services.

(b) Funds deposited in the state-operated services account are appropriated to the commissioner of human services for the purposes of:

(1) providing services needed to transition individuals from institutional settings within state-operated services to the community when those services have no other adequate funding source; and

(2) funding the operation of the intensive residential treatment service program in Willmar.

Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds to the account in subdivision 8 for noncovered allowable costs of a provider certified and licensed under section 256B.0622 and operating under section 246.014.

252.41 DEFINITIONS.

Subd. 8. **Supported employment.** "Supported employment" means employment of a person with a disability so severe that the person needs ongoing training and support to get and keep a job in which:

(1) the person engages in paid work at a work site where individuals without disabilities who do not require public subsidies also may be employed;

(2) public funds are necessary to provide ongoing training and support services throughout the period of the person's employment; and

(3) the person has the opportunity for social interaction with individuals who do not have disabilities and who are not paid caregivers.

252.431 SUPPORTED EMPLOYMENT SERVICES; DEPARTMENTAL DUTIES; COORDINATION.

The commissioners of employment and economic development, human services, and education shall ensure that supported employment services provided as part of a comprehensive service system will:

(1) provide the necessary supports to assist persons with severe disabilities to obtain and maintain employment in normalized work settings available to the general work force that:

(i) maximize community and social integration; and

(ii) provide job opportunities that meet the individual's career potential and interests;

(2) allow persons with severe disabilities to actively participate in the planning and delivery of community-based employment services at the individual, local, and state level; and

(3) be coordinated among the Departments of Human Services, Employment and Economic Development, and Education to:

(i) promote the most efficient and effective funding;

(ii) avoid duplication of services; and

(iii) improve access and transition to employability services.

The commissioners of employment and economic development, human services, and education shall report to the legislature by January 1993 on the steps taken to implement this section.

252.451 BUSINESS AGREEMENTS; SUPPORT AND SUPERVISION OF PERSONS WITH DISABILITIES.

Subdivision 1. **Definition.** For the purposes of this section, "qualified business" means a business that employs primarily nondisabled persons and will employ persons with developmental disabilities. For purposes of this section, licensed providers of residential services for persons with developmental disabilities are not a qualified business. A qualified business and its employees are exempt from Minnesota Rules, parts 9525.1800 to 9525.1930.

Subd. 2. **Vendor participation and reimbursement.** Notwithstanding requirements in chapters 245A and 245D, and sections 252.28, 252.41 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.

Subd. 3. **Agreement specifications.** Agreements must include the following:

(1) the type and amount of supervision and support to be provided by the business to the individual in accordance with their needs as identified in their individual service plan;

(2) the methods used to periodically assess the individual's satisfaction with their work, training, and support;

(3) the measures taken by the qualified business and the vendor to ensure the health, safety, and protection of the individual during working hours, including the reporting of abuse and neglect under state law and rules;

(4) the training and support services the vendor will provide to the qualified business, including the frequency of on-site supervision and support; and

(5) any payment to be made to the qualified business by the vendor. Payment to the business must be limited to:

(i) additional costs of training coworkers and managers that exceed ordinary and customary training costs and are a direct result of employing a person with a developmental disability; and

(ii) additional costs for training, supervising, and assisting the person with a developmental disability that exceed normal and customary costs required for performing similar tasks or duties.

Payments made to a qualified business under this section must not include incentive payments to the qualified business or salary supplementation for the person with a developmental disability.

Subd. 4. **Client protection.** Persons receiving training and support under this section may not be denied their rights or procedural protections under section 256.045, subdivision 4a, or 256B.092, including the county agency's responsibility to arrange for appropriate services, as necessary, in the event that persons lose their job or the contract with the qualified business is terminated.

Subd. 5. **Vendor payment.** (a) For purposes of this section, the vendor shall bill and the commissioner shall reimburse the vendor for full-day or partial-day services to a client that would otherwise have been paid to the vendor for providing direct services, provided that both of the following criteria are met:

(1) the vendor provides services and payments to the qualified business that enable the business to perform support and supervision services for the client that the vendor would otherwise need to perform; and

(2) the client for whom a rate will be billed will receive full-day or partial-day services from the vendor and the rate to be paid the vendor will allow the client to work with this support and supervision at the qualified business instead of receiving these services from the vendor.

(b) Medical assistance reimbursement of services provided to persons receiving day training and habilitation services under this section is subject to the limitations on reimbursement for vocational services under federal law and regulation.

254B.03 RESPONSIBILITY TO PROVIDE CHEMICAL DEPENDENCY TREATMENT.

Subd. 4a. **Division of costs for medical assistance services.** Notwithstanding subdivision 4, for chemical dependency services provided on or after October 1, 2008, and reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

256B.0625 COVERED SERVICES.

Subd. 31c. **Preferred incontinence product program.** The commissioner shall implement a preferred incontinence product program by July 1, 2018. The program shall require the commissioner to volume purchase incontinence products and related supplies in accordance with section 256B.04, subdivision 14. Medical assistance coverage for incontinence products and related supplies shall conform to the limitations established under the program.

Subd. 63. **Payment for multiple services provided on the same day.** The commissioner shall not prohibit payment, including supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health or dental services were provided on the same day as other covered health services furnished by the same provider.

256B.0659 PERSONAL CARE ASSISTANCE PROGRAM.

Subd. 22. **Annual review for personal care providers.** (a) All personal care assistance provider agencies shall resubmit, on an annual basis, the information specified in subdivision 21, in a format

determined by the commissioner, and provide a copy of the personal care assistance provider agency's most current version of its grievance policies and procedures along with a written record of grievances and resolutions of the grievances that the personal care assistance provider agency has received in the previous year and any other information requested by the commissioner.

(b) The commissioner shall send annual review notification to personal care assistance provider agencies 30 days prior to renewal. The notification must:

(1) list the materials and information the personal care assistance provider agency 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.

Personal care assistance provider agencies shall submit required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the personal care assistance provider agency enrollment number must be terminated or suspended.

(c) Personal care assistance provider agencies also currently licensed under section 144A.471, subdivision 6 or 7, or currently certified for participation in Medicare as a home health agency are deemed in compliance with the personal care assistance requirements for enrollment, annual review process, and documentation.

256B.0705 PERSONAL CARE ASSISTANCE SERVICES; MANDATED SERVICE VERIFICATION.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Personal care assistance services" or "PCA services" means services provided according to section 256B.0659.

(c) "Personal care assistant" or "PCA" has the meaning given in section 256B.0659, subdivision 1.

(d) "Service verification" means a random, unscheduled telephone call made for the purpose of verifying that the individual personal care assistant is present at the location where personal care assistance services are being provided and is providing services as scheduled.

Subd. 2. **Verification schedule.** An agency that submits claims for reimbursement for PCA services under this chapter must develop and implement administrative policies and procedures by which the agency verifies the services provided by a PCA. For each service recipient, the agency must conduct at least one service verification every 90 days. If more than one PCA provides services to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement under section 256B.0659, subdivision 14 or 19.

Subd. 3. **Documentation of verification.** An agency must fully document service verifications in a legible manner and must maintain the documentation on site for at least five years from the date of documentation. For each service verification, documentation must include:

(1) the names and signatures of the service recipient or recipient's authorized representative, the PCA and any other agency staff present with the PCA during the service verification, and the staff person conducting the service verification; and

(2) the start and end time, day, month, and year of the service verification, and the corresponding PCA time sheet.

Subd. 4. **Variance.** The Office of Inspector General at the Department of Human Services may grant a variance to the service verification requirements in this section if an agency uses an electronic monitoring system or other methods that verify a PCA is present at the location where services are provided and is providing services according to the prescribed schedule. A decision to grant or deny a variance request is final and not subject to appeal under chapter 14.

256B.431 RATE DETERMINATION.

Subd. 3i. **Property costs for the rate year beginning July 1, 1990.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, the commissioner shall determine property-related payment rates for nursing facilities for the rate year beginning July 1, 1990, as follows:

(a) The property-related payment rate for a nursing facility that qualifies under subdivision 3g is the greater of the rate determined under that subdivision or the rate determined under paragraph (c), (d), or (e), whichever is applicable.

(b) Nursing facilities shall be grouped according to the type of property-related payment rate the commissioner determined for the rate year beginning July 1, 1989. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item A (full rental reimbursement), shall be considered group A. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item B (phase-down to full rental reimbursement), shall be considered group B. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item C or D (phase-up to full rental reimbursement), shall be considered group C.

(c) For the rate year beginning July 1, 1990, a group A nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(d) For the rate year beginning July 1, 1990, a Group B nursing facility shall receive the greater of 87 percent of the property-related payment rate in effect on July 1, 1989; or the rental per diem rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section in effect on July 1, 1990; or the sum of 100 percent of the nursing facility's allowable principal and interest expense, plus its equipment allowance multiplied by the resident days for the reporting year ending September 30, 1989, divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c); except that the nursing facility's property-related payment rate must not exceed its property-related payment rate in effect on July 1, 1989.

(e) For the rate year beginning July 1, 1990, a group C nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, except the rate must not exceed the lesser of its property-related payment rate determined for the rate year beginning July 1, 1989, multiplied by 116 percent or its rental per diem rate determined effective July 1, 1990.

(f) The property-related payment rate for a nursing facility that qualifies for a rate adjustment under Minnesota Rules, part 9549.0060, subpart 13, item G (special reappraisals), shall have the property-related payment rate determined in paragraphs (a) to (e) adjusted according to the provisions in that rule.

(g) Except as provided in subdivision 4, paragraph (f), and subdivision 11, a nursing facility that has a change in ownership or a reorganization of provider entity is subject to the provisions of Minnesota Rules, part 9549.0060, subpart 13, item F.

Subd. 15. **Capital repair and replacement cost reporting and rate calculation.** For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in paragraphs (a) to (e).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of any of the following items not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair; and

(6) window repair or replacement.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the repair or replacement of a capital asset not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), must be reported under this subdivision when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

(c) To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under subdivision 14, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in subdivision 14, paragraph (f), for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in subdivision 3f, paragraph (a). For purposes of this subdivision, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

(d) Capital repair and replacement costs under this subdivision shall not be counted as either care-related or other operating costs, nor subject to care-related or other operating limits.

(e) If costs otherwise allowable under this subdivision are incurred as the result of a project approved under the moratorium exception process in section 144A.073, or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under subdivision 16 or 17, as appropriate.

Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning after June 30, 1993, if a nursing facility acquires capital assets in connection with a project approved under the moratorium exception process in section 144A.073 or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of those capital asset additions exceeds the lesser of $150,000 or ten percent of the most recent appraised value, the nursing facility shall be eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation is separate from the determination of the nursing facility's rental rate. An equity incentive payment rate as computed under this subdivision is limited to one in a 12-month period.

(a) An eligible nursing facility shall receive an equity incentive payment rate equal to the allowable historical cost of the capital asset acquired, minus the allowable debt directly identified to that capital asset, multiplied by the equity incentive factor as described in paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total payment rate and shall be effective the same day as the incremental increase in paragraph (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) The equity incentive factor shall be determined under clauses (1) to (4):

(1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the capital asset additions referred to in paragraph (a), then cube the quotient,

(2) subtract the amount calculated in clause (1) from the number one,

(3) determine the difference between the rental factor and the lesser of two percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on the first day of the month the debt or cost is incurred, or 16 percent,

(4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

(c) The equity incentive payment rate shall be limited to the term of the allowable debt in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The sale of a nursing facility under subdivision 14 shall terminate application of the equity incentive payment rate effective on the date provided in subdivision 14, paragraph (f), for the sale.

(d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures, or land improvements meeting the criteria in this subdivision and not receiving the property-related payment rate adjustment in subdivision 17, shall receive the incremental increase in the nursing facility's rental rate as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the nursing facility's property-related payment rate. The effective date of this incremental increase shall be the first day of the month of January or July, whichever occurs first following the date on which the addition or replacement is completed.

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

Subd. 6. **Contract payment rates; appeals.** If an appeal is pending concerning the cost-based payment rates that are the basis for the calculation of the payment rate under the alternative payment demonstration project, the commissioner and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively in accordance with the appeal decision.

Subd. 10. **Exemptions.** A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this subdivision. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this subdivision that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

256B.4913 PAYMENT METHODOLOGY DEVELOPMENT.

Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision, "implementation period" means the period beginning January 1, 2014, and ending on the last day of the month in which the rate management system is populated with the data necessary to calculate rates for substantially all individuals receiving home and community-based waiver services under sections 256B.092 and 256B.49. "Banding period" means the time period beginning on January 1, 2014, and ending upon the expiration of the 12-month period defined in paragraph (c), clause (5).

(b) For purposes of this subdivision, the historical rate for all service recipients means the individual reimbursement rate for a recipient in effect on December 1, 2013, except that:

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for the provider number in the county of service, effective December 1, 2013; or

(2) for a unit-based service with programming or a unit-based service without programming recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for each provider number in the county of service, effective December 1, 2013; or

(3) for residential service recipients who change providers on or after January 1, 2014, the historical rate must be set by each lead agency within their county aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the historical rate for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3);

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4);

(6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately following the time period of clause (5). During this banding rate period, the commissioner shall not enforce any rate decrease or increase that would otherwise result from the end of the banding period. The commissioner shall, upon enactment, seek federal approval for the addition of this banding period; and

(7) one percent from the rate in effect in clause (6) for the 12-month period immediately following the time period of clause (6).

(d) The commissioner shall review all changes to rates that were in effect on December 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service unit utilization on an annual basis as those in effect on October 31, 2013.

(e) By December 31, 2014, the commissioner shall complete the review in paragraph (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

(f) During the banding period, the Medicaid Management Information System (MMIS) service agreement rate must be adjusted to account for change in an individual's need. The commissioner shall adjust the Medicaid Management Information System (MMIS) service agreement rate by:

(1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the level of service in effect on December 1, 2013;

(2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the updated level of service at the time of application; and

(3) adding to or subtracting from the Medicaid Management Information System (MMIS) service agreement rate, the difference between the values in clauses (1) and (2).

(g) This subdivision must not apply to rates for recipients served by providers new to a given county after January 1, 2014. Providers of personal supports services who also acted as fiscal support entities must be treated as new providers as of January 1, 2014.

Subd. 5. **Stakeholder consultation and county training.** (a) The commissioner shall continue consultation on regular intervals with the existing stakeholder group established as part of the rate-setting methodology process and others, to gather input, concerns, and data, to assist in the full implementation of the new rate payment system and to make pertinent information available to the public through the department's website.

(b) The commissioner shall offer training at least annually for county personnel responsible for administering the rate-setting framework in a manner consistent with this section and section 256B.4914.

(c) The commissioner shall maintain an online instruction manual explaining the rate-setting framework. The manual shall be consistent with this section and section 256B.4914, and shall be accessible to all stakeholders including recipients, representatives of recipients, county or tribal agencies, and license holders.

(d) The commissioner shall not defer to the county or tribal agency on matters of technical application of the rate-setting framework, and a county or tribal agency shall not set rates in a manner that conflicts with this section or section 256B.4914.

Subd. 6. **Implementation.** (a) The commissioner shall implement changes on January 1, 2014, to payment rates for individuals receiving home and community-based waivered services after the enactment of legislation that establishes specific payment methodology frameworks, processes for rate calculations, and specific values to populate the disability waiver rates system.

(b) On January 1, 2014, all new service authorizations must use the disability waiver rates system. Beginning January 1, 2014, all renewing individual service plans must use the disability waiver rates system as reassessment and reauthorization occurs. By December 31, 2014, data for all recipients must be entered into the disability waiver rates system.

Subd. 7. **New services.** A service added to section 256B.4914 after January 1, 2014, is not subject to rate stabilization adjustment in this section.

256B.79 INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN.

Subd. 7. **Expiration.** This section expires June 30, 2019.

256I.05 MONTHLY RATES.

Subd. 3. **Limits on rates.** When a room and board rate is used to pay for an individual's room and board, the rate payable to the residence must not exceed the rate paid by an individual not receiving a room and board rate under this chapter.

256L.11 PROVIDER PAYMENT.

Subd. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

256R.53 FACILITY SPECIFIC EXEMPTIONS.

Subd. 2. **Nursing facility in Breckenridge.** The operating payment rate of a nonprofit nursing facility that exists on January 1, 2015, is located within the boundaries of the city of Breckenridge, and is reimbursed under this chapter, is equal to the greater of:

(1) the operating payment rate determined under section 256R.21, subdivision 3; or

(2) the median case mix adjusted rates, including comparable rate components as determined by the median case mix adjusted rates, including comparable rate components as determined by the commissioner, for the equivalent case mix indices of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The Minnesota facility's operating payment rate with a case mix index of 1.0 is computed by dividing the adjacent city's nursing facility or facilities' median operating payment rate with an index of 1.02 by 1.02.

Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10

Sec. 3. **COMMISSIONER OF HUMAN SERVICES**

Subd. 10. **State-Operated Services**

Obsolete Laundry Depreciation Account. $669,000, or the balance, whichever is greater, must be transferred from the state-operated services laundry depreciation account in the special revenue fund and deposited into the general fund by June 30, 2010. This paragraph is effective the day following final enactment.

Operating Budget Reductions. No operating budget reductions enacted in Laws 2010, chapter 200, or in this act shall be allocated to state-operated services.

Prohibition on Transferring Funds. The commissioner shall not transfer mental health grants to state-operated services without specific legislative approval. Notwithstanding any contrary provision in this article, this paragraph shall not expire.

(a) **Adult Mental Health Services**	-0-	6,888,000

Base Adjustment. The general fund base is decreased by $12,286,000 in fiscal year 2012 and $12,394,000 in fiscal year 2013.

Appropriation Requirements. (a) The general fund appropriation to the commissioner includes funding for the following:

(1) to a community collaborative to begin providing crisis center services in the Mankato area that are comparable to the crisis services provided prior to the closure of the Mankato Crisis Center. The commissioner shall recruit former employees of the Mankato Crisis Center who were recently laid off to staff the new crisis services. The commissioner shall obtain legislative approval prior to discontinuing this funding;

(2) to maintain the building in Eveleth that currently houses community transition services and to establish a psychiatric intensive therapeutic foster home as an enterprise activity. The commissioner shall request a waiver amendment to allow CADI funding for psychiatric intensive therapeutic foster care services provided in the same location and building as the community transition services. If the federal government does not approve the waiver amendment, the commissioner shall continue to pay the lease for the building out of the state-operated services budget until the commissioner of administration subleases the space or until the lease expires, and shall establish the psychiatric intensive therapeutic foster home at a different site. The commissioner shall make diligent efforts to sublease the space;

(3) to convert the community behavioral health hospitals in Wadena and Willmar to facilities that

provide more suitable services based on the needs of the community, which may include, but are not limited to, psychiatric extensive recovery treatment services. The commissioner may also establish other community-based services in the Willmar and Wadena areas that deliver the appropriate level of care in response to the express needs of the communities. The services established under this provision must be staffed by state employees.

(4) to continue the operation of the dental clinics in Brainerd, Cambridge, Faribault, Fergus Falls, and Willmar at the same level of care and staffing that was in effect on March 1, 2010. The commissioner shall not proceed with the planned closure of the dental clinics, and shall not discontinue services or downsize any of the state-operated dental clinics without specific legislative approval. The commissioner shall continue to bill for services provided to obtain medical assistance critical access dental payments and cost-based payment rates as provided in Minnesota Statutes, section 256B.76, subdivision 2, and shall bill for services provided three months retroactively from the date of this act. This appropriation is onetime;

(5) to convert the Minnesota Neurorehabilitation Hospital in Brainerd to a neurocognitive psychiatric extensive recovery treatment service; and

(6) to convert the Minnesota extended treatment options (METO) program to the following community-based services provided by state employees: (i) psychiatric extensive recovery treatment services; (ii) intensive transitional foster homes as enterprise activities; and (iii) other community-based support services. The provisions under Minnesota Statutes, section 252.025, subdivision 7, are applicable to the METO services established under this clause. Notwithstanding Minnesota Statutes, section 246.18, subdivision 8, any revenue lost to the general fund by the conversion of METO to new services must be replaced by revenue from the new services to offset the lost revenue to the general fund until June 30, 2013. Any revenue generated in excess of this amount shall be deposited into the special revenue fund under Minnesota Statutes, section 246.18, subdivision 8.

(b) The commissioner shall not move beds from the Anoka-Metro Regional Treatment Center to the psychiatric nursing facility at St. Peter without specific legislative approval.

(c) The commissioner shall implement changes, including the following, to save a minimum of $6,006,000 beginning in fiscal year 2011, and report to the legislature the specific initiatives implemented and the savings allocated to each one, including:

(1) maximizing budget savings through strategic employee staffing; and

(2) identifying and implementing cost reductions in cooperation with state-operated services employees.

Base level funding is reduced by $6,006,000 effective fiscal year 2011.

(d) The commissioner shall seek certification or approval from the federal government for the new services under paragraph (a) that are eligible for federal financial participation and deposit the revenue associated with these new services in the account established under Minnesota Statutes, section 246.18, subdivision 8, unless otherwise specified.

(e) Notwithstanding any contrary provision in this article, this rider shall not expire.

(b) **Minnesota Sex Offender Services**	-0-	(145,000)

Sex Offender Services. Base level funding for Minnesota sex offender services is reduced by $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013 for the 50-bed sex offender treatment program within the Moose Lake correctional facility in which Department of Human Services staff from Minnesota sex offender services provide clinical treatment to incarcerated offenders. This reduction shall become part of the base for the Department of Human Services.

Interagency Agreements. The commissioner of human services may enter into interagency agreements with the commissioner of corrections to continue sex offender treatment and chemical dependency treatment on a cost-sharing basis, in which each department pays 50 percent of the costs of these services.

Base Adjustment. The general fund base is increased by $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013.

2960.3030 CAPACITY LIMITS.

Subp. 3. **Exceptions to capacity limits.** A variance may be granted to allow up to eight foster children in addition to the license holder's own children if the conditions in items A to E are met:

A. placement is necessary to keep a sibling group together, to keep a child in the child's home community, or is necessary because the foster child was formerly living in the home and it would be in the child's best interest to be placed there again;

B. there is no risk of harm to the children currently in the home;

C. the structural characteristics of the home, including sleeping space, can accommodate the additional foster children;

D. the home remains in compliance with applicable zoning, health, fire, and building codes; and

E. the statement of intended use states the conditions for the exception to capacity limits and explains how the license holder will maintain a ratio of adults to children which ensures the safety and appropriate supervision of all the children in the foster home.

A foster home licensed by the Department of Corrections need not meet the requirement in item A.

3400.0185 TERMINATION AND ADVERSE ACTIONS; NOTICE REQUIRED.

Subp. 5. **Notice to providers of actions adverse to the provider.** The county must give a provider written notice of the following actions adverse to the provider: a denial of authorization, a termination of authorization, a reduction in the number of hours of care with that provider, and a determination that the provider has an overpayment. The notice must include the following information:

A. a description of the adverse action;

B. the effective date of the adverse action; and

C. a statement that unless a family appeals the adverse action before the effective date or the provider appeals the overpayment determination, the adverse action will occur on the effective date. The notice must be mailed to the provider at least 15 calendar days before the effective date of the adverse action.

6400.6970 FEES.

Subpart 1. **Payment types and nonrefundability.** The fees imposed in this part shall be paid by cash, personal check, bank draft, cashier's check, or money order made payable to the Board of Examiners for Nursing Home Administrators. All fees are nonrefundable.

Subp. 2. **Amounts.** The amount of fees may be set by the board with the approval of the Department of Management and Budget up to the limits provided in this part depending upon the total amount required to sustain board operations under Minnesota Statutes, section 16A.1285, subdivision 2. Information about fees in effect at any time is available from the board office. The maximum amounts of fees are:

A. application for licensure, $150;

B. for a prospective applicant for a review of education and experience advisory to the license application, $50, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;

C. state examination, $75;

D. initial license, $200 if issued between July 1 and December 31, $100 if issued between January 1 and June 30;

E. acting administrator permit, $250;

F. renewal license, $200;

G. duplicate license, $10;

H. fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:

(1) for less than seven clock hours, $30; and

(2) for seven or more clock hours, $50;

I. fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:

(1) for less than seven clock hours total, $30; and

(2) for seven or more clock hours total, $50;

J. late renewal fee, $50;

K. fee to a licensee for verification of licensure status and examination scores, $30; and

L. registration as a registered continuing education sponsor, $1,000.

7200.6100 FEES.

The nonrefundable fees for licensure payable to the board are as follows:

A. application for admission to national standardized examination, $150;

B. application for professional responsibility examination, $150;

C. application for licensure as a licensed psychologist, $500;

D. renewal of license for a licensed psychologist, $500;

E. late renewal of license for a licensed psychologist, $250;

F. application for converting from master's to doctoral level licensure, $150; and

G. application for guest licensure, $150.

7200.6105 CONTINUING EDUCATION SPONSOR FEE.

A sponsor applying for approval of a continuing education activity pursuant to part 7200.3830, subpart 2, shall submit with the application a fee of $80 for each activity.

9502.0425 PHYSICAL ENVIRONMENT.

Subp. 4. **Means of escape.** From each room of the residence used by children, there must be two means of escape. One means of escape must be a stairway or door leading to the floor of exit discharge. The other must be a door or window leading directly outside. The window must be openable without special knowledge. It must have a clear opening of not less than 5.7 square feet and have a minimum clear opening dimension of 20 inches wide and 24 inches high. The window must be within 48 inches from the floor.

Subp. 16. **Extinguishers.** A portable, operational, multipurpose, dry chemical fire extinguisher with a minimum 2 A 10 BC rating must be maintained in the kitchen and cooking areas of the residence at all times. All caregivers shall know how to use the fire extinguisher.

Subp. 17. **Smoke detection systems.** Smoke detectors that have been listed by the Underwriter Laboratory must be properly installed and maintained on all levels.

9503.0155 FACILITY.

Subp. 8. **Telephone; posted numbers.** A telephone that is not coin operated must be located within the center. A list of emergency numbers must be posted next to the telephone. If a 911 emergency number is not available, the numbers listed must be those of the local fire department, police department, emergency transportation, and poison control center.

9549.0057 DETERMINATION OF INTERIM AND SETTLE UP OPERATING COST PAYMENT RATES.

Subpart 1. **Conditions.** To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to subparts 2 and 3.

Subp. 2. **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 (Temporary) in effect on March 1, 1987. For the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to parts 9549.0051 to 9549.0059, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

E. The limits established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3 and in effect at the beginning of the interim period, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

G. The phase in provisions in part 9549.0056, subpart 7, must not apply.

Subp. 3. **Settle up operating cost payment rate.** The settle up total operating cost payment rate must be determined according to items A to C.

A. The settle up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in part 9549.0054, subpart 2, must be used for the interim period.

(2) The commissioner shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

(5) The limits established in part 9549.0055, subpart 2, item E, must be the limits for the settle up reporting periods occurring after July 1, 1987. If the interim period includes more than one July 1 date, the commissioner shall use the limit established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3, increased by ten percent for the second July 1 date.

(6) The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

(7) The phase in provisions in part 9549.0056, subpart 7 must not apply.

C. For the nine month period following the settle up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in part 9549.0056, subpart 4, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine month period in item C must be determined under parts 9549.0050 to 9549.0059.

E. A newly constructed nursing facility or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle up total operating cost payment rate is determined under this subpart.

9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.

Subp. 14. **Determination of interim and settle-up payment rates.** The commissioner shall determine interim and settle-up payment rates according to items A to J.

A. A newly constructed nursing facility, or one with a capacity increase of 50 percent or more, may submit a written application to the commissioner to receive an interim payment rate. The nursing facility shall submit cost reports and other supporting information as required in parts 9549.0010 to 9549.0080 for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The nursing facility shall state the reasons for noncompliance with parts 9549.0010 to 9549.0080. The effective date of the interim payment rate is the earlier of either the first day a resident is admitted to the newly constructed nursing facility or the date the nursing facility bed is certified for medical assistance. The interim payment rate for a newly constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, is determined under items B to D.

B. The interim payment rate must not be in effect more than 17 months. When the interim payment rate begins between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year. When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

C. The interim payment rate for a nursing facility which commenced construction prior to July 1, 1985, is determined by 12 MCAR S 2.05014 [Temporary] except that capital assets must be classified under parts 9549.0010 to 9549.0080.

D. The interim property-related payment rate for a nursing facility which commences construction after June 30, 1985, is determined as follows:

(1) At least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed and upon receipt of written application from the nursing facility, the commissioner shall establish the nursing facility's appraised value according to subparts 1 and 4.

(2) The nursing facility shall project the allowable debt and the allowable interest expense according to subparts 5 and 7.

(3) The interim building capital allowance must be determined under subpart 8 or 9.

(4) The equipment allowance during the interim period must be the equipment allowance computed in accordance with subpart 10 which is in effect on the effective date of the interim property-related payment rate.

(5) The interim property-related payment rate must be the sum of subitems (3) and (4).

(6) Anticipated resident days may be used instead of 96 percent capacity days.

E. The settle-up property-related payment rate and the property-related payment rate for the nine months following the settle up for a nursing facility which commenced construction before July 1, 1985, is determined under 12 MCAR S 2.05014 [Temporary]. The property-related payment rate for the rate year beginning July 1 following the nine month period is determined under part 9549.0060.

F. The settle-up property-related payment rate for a nursing facility which commenced construction after June 30, 1985, shall be established as follows:

(1) The appraised value determined in item D, subitem (1), must be updated in accordance with subpart 2, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with subparts 5, 6, and 7.

(3) The settle-up building capital allowance shall be determined in accordance with subpart 8 or 9.

(4) The equipment allowance shall be updated in accordance with subpart 10 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(5) The settle-up property-related payment rate must be the sum of subitems (3) and (4).

(6) Resident days may be used instead of 96 percent capacity days.

G. The property-related payment rate for the nine months following the settle up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 96 percent capacity days must be used.

H. The property-related payment rate for the rate year beginning July 1 following the nine month period in item G must be determined under this part.

I. A newly constructed nursing facility or one with a capacity increase of 50 percent or more must continue to receive the interim property-related payment rate until the settle-up property-related payment rate is determined under this subpart.

J. The interim real estate taxes and special assessments payment rate shall be established using the projected real estate taxes and special assessments cost divided by anticipated resident days. The settle-up real estate taxes and special assessments payment rate shall be established using the real estate taxes and special assessments divided by

resident days. The real estate and special assessments payment rate for the nine months following the settle up shall be equal to the settle-up real estate taxes and special assessments payment rate.