SENATE
STATE OF MINNESOTA
SPECIAL SESSION

S.F. No. 2

(SENATE AUTHORS: BENSON and Abeler)

DATE	D-PG	OFFICIAL STATUS
05/24/2017		Introduction and first reading

A bill for an act

relating to state government; establishing the health and human services budget; modifying provisions governing community supports, housing, continuing care, health care, health insurance, direct care and treatment, children and families, chemical and mental health services, Department of Human Services operations, Health Department, health licensing boards, opiate abuse prevention, managed care organizations, and child care development block grant compliance; making technical changes; modifying terminology and definitions; establishing licensing fix-it tickets; requiring reports; establishing moratorium on conversion transactions; modifying fees; making forecast adjustments; appropriating money; amending Minnesota Statutes 2016, sections 3.972, by adding subdivisions; 13.32, by adding a subdivision; 13.46, subdivisions 1, 2; 13.84, subdivision 5; 62A.04, subdivision 1; 62A.21, subdivision 2a; 62A.3075; 62D.105; 62E.04, subdivision 11; 62E.05, subdivision 1; 62E.06, by adding a subdivision; 62K.15; 62U.02; 103I.005, subdivisions 2, 2a, 12, 20a, 21, by adding subdivisions; 103I.101, subdivisions 2, 5, 6; 103I.105; 103I.111, subdivisions 6, 8; 103I.205, subdivisions 1, 2, 3, 4, 5, 6; 103I.208, subdivisions 1, 2; 103I.235, by adding a subdivision; 103I.301, subdivisions 1, 2; 103I.315, subdivision 1; 103I.501; 103I.505, subdivisions 1, 2; 103I.515; 103I.525, subdivisions 1, 2, 5, 6, 8; 103I.531, subdivisions 2, 5; 103I.535, subdivisions 2, 6; 103I.541, subdivisions 1, 2, 2a, 2b, 2c, 2e, 3, 4, 5; 103I.545; 103I.601, subdivisions 2, 4; 103I.711, subdivision 1; 103I.715, subdivision 2; 119B.011, subdivisions 20, 20a; 119B.025, subdivision 1, by adding subdivisions; 119B.03, subdivision 3; 119B.05, subdivision 1; 119B.09, subdivisions 1, 4; 119B.10, subdivision 1, by adding a subdivision; 119B.12, subdivision 2; 119B.13, subdivisions 1, 6; 144.0722, subdivision 1, as amended; 144.0724, subdivisions 4, 6; 144.122; 144.1501, subdivision 2; 144.4961, subdivisions 3, 4, 5; 144.551, subdivision 1; 144.562, subdivision 2; 144.99, subdivision 1; 144A.071, subdivisions 3, as amended, 4a, as amended, 4c, as amended, 4d, as amended; 144A.10, subdivision 4, as amended; 144A.351, subdivision 1; 144A.472, subdivision 7; 144A.4799, subdivision 3; 144A.70, subdivision 6, by adding a subdivision; 144A.74; 144D.04, subdivision 2, by adding a subdivision; 144D.06; 145.4131, subdivision 1; 145.4716, subdivision 2; 145.928, subdivision 13; 145.986, subdivision 1a; 146B.02, subdivisions 2, 3, 5, 8, by adding subdivisions; 146B.03, subdivisions 6, 7, as amended; 146B.07, subdivision 2; 146B.10, subdivisions 1, 2, by adding a subdivision; 147.01, subdivision 7; 147.02, subdivision 1; 147.03, subdivision 1; 147B.08, by adding a subdivision; 147C.40, by adding a subdivision; 148.514, subdivision 1; 148.519, subdivisions 1, 2; 148.5194, subdivisions 2, 3, 4, 7, by adding a subdivision; 148.5195, subdivision 2; 148.6402, subdivision 4; 148.6405; 148.6408, subdivision 2; 148.6410, subdivision 2; 148.6412, subdivision

2; 148.6415; 148.6418, subdivisions 1, 2, 4, 5; 148.6420, subdivisions 1, 3, 5; 148.6423; 148.6425, subdivisions 2, 3; 148.6428; 148.6443, subdivisions 5, 6, 7, 8; 148.6445, subdivisions 1, 10; 148.6448; 148.881; 148.89; 148.90, subdivisions 1, 2; 148.905, subdivision 1; 148.907, subdivisions 1, 2; 148.9105, subdivisions 1, 4, 5; 148.916, subdivisions 1, 1a; 148.925; 148.96, subdivision 3; 148.997, subdivision 1; 148B.53, subdivision 1; 150A.06, subdivisions 3, 8; 150A.10, subdivision 4; 151.212, subdivision 2; 152.11, by adding a subdivision; 152.25, subdivision 1, by adding subdivisions; 152.28, by adding a subdivision; 152.33, by adding a subdivision; 153A.14, subdivisions 1, 2; 153A.17; 157.16, subdivisions 1, 3, 3a; 214.01, subdivision 2; 245.462, subdivision 9; 245.467, subdivision 2; 245.4871, by adding subdivisions; 245.4876, subdivision 2; 245.4889, subdivision 1; 245.814, by adding a subdivision; 245.91, subdivisions 4, 6; 245.94, subdivision 1; 245.97, subdivision 6; 245A.02, subdivisions 2b, 5a, by adding subdivisions; 245A.03, subdivisions 2, 7; 245A.04, subdivisions 4, 14; 245A.06, subdivisions 2, 8, by adding a subdivision; 245A.07, subdivision 3; 245A.09, subdivision 7; 245A.10, subdivision 2; 245A.11, by adding subdivisions; 245A.14, by adding a subdivision; 245A.16, subdivision 1, by adding a subdivision; 245A.191; 245A.40, by adding a subdivision; 245A.50, subdivision 5; 245C.02, by adding a subdivision; 245C.03, subdivision 1, by adding a subdivision; 245C.04, subdivisions 1, 8; 245C.05, subdivisions 2b, 4, 5, 7; 245C.08, subdivisions 1, 2, 4; 245C.09, by adding a subdivision; 245C.10, subdivision 9, by adding subdivisions; 245C.11, subdivision 3; 245C.15; 245C.16, subdivision 1; 245C.17, subdivision 6; 245C.21, subdivision 1; 245C.22, subdivisions 5, 7; 245C.23; 245C.24, subdivision 3; 245C.25; 245C.30, subdivision 2; 245D.03, subdivision 1; 245D.04, subdivision 3; 246.18, subdivision 4, by adding a subdivision; 252.27, subdivision 2a; 252.41, subdivision 3; 252.50, subdivision 5; 253B.10, subdivision 1; 254A.01; 254A.02, subdivisions 2, 3, 5, 6, 8, 10, by adding subdivisions; 254A.03; 254A.035, subdivision 1; 254A.04; 254A.08; 254A.09; 254A.19, subdivision 3; 254B.01, subdivision 3, by adding a subdivision; 254B.03, subdivision 2; 254B.04, subdivisions 1, 2b; 254B.05, subdivisions 1, 1a, 5; 254B.051; 254B.07; 254B.08; 254B.09; 254B.12, subdivision 2, by adding a subdivision; 254B.13, subdivision 2a; 256.01, by adding a subdivision; 256.045, subdivisions 3, 3a; 256.9657, subdivision 1; 256.9685, subdivisions 1, 1a; 256.9686, subdivision 8; 256.969, subdivisions 1, 2b, 3a, 8, 8c, 9, 12; 256.9695, subdivision 1; 256.975, subdivision 7, by adding a subdivision; 256B.04, subdivisions 12, 24; 256B.056, subdivisions 3b, 3c, 5c; 256B.0561, subdivisions 2, 4; 256B.057, subdivision 9, as amended; 256B.059, subdivision 6, as amended; 256B.0621, subdivision 10; 256B.0625, subdivisions 1, 3b, 6a, 7, 17, 17b, 18h, 20, 31, 45a, 64, by adding subdivisions; 256B.0644; 256B.0653, subdivisions 2, 3, 4, as amended, 5, 6, by adding a subdivision; 256B.072; 256B.0755, subdivisions 1, 3, 4, by adding a subdivision; 256B.0911, subdivisions 1a, 2b, 3a, 4d, as amended, 5, 6, as amended, by adding a subdivision; 256B.0915, subdivisions 1, 3a, 3e, 3h, 5, by adding subdivisions; 256B.092, subdivision 4; 256B.0921; 256B.0924, by adding a subdivision; 256B.0943, subdivision 13; 256B.0945, subdivisions 2, 4; 256B.196, subdivisions 2, 3, 4; 256B.35, subdivision 4, as amended; 256B.431, subdivisions 10, 16, 30; 256B.434, subdivisions 4, 4f; 256B.49, subdivisions 11, 15; 256B.4913, subdivision 4a, by adding a subdivision; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 16, by adding a subdivision; 256B.493, subdivisions 1, 2, by adding a subdivision; 256B.50, subdivision 1b; 256B.5012, by adding subdivisions; 256B.69, subdivision 9e, by adding subdivisions; 256B.75; 256B.76, subdivisions 1, as amended, 2; 256B.761; 256B.763; 256B.766; 256C.21; 256C.23, subdivisions 1, 2, by adding subdivisions; 256C.233, subdivisions 1, 2, 4; 256C.24; 256C.25, subdivision 1; 256C.261; 256C.30; 256D.44, subdivisions 4, as amended, 5, as amended; 256E.30, subdivision 2; 256I.03, subdivision 8; 256I.04, subdivisions 1, 2d, 2g, 3; 256I.05, subdivisions 1a, 1c, 1e, 1j, 1m, by adding subdivisions; 256I.06, subdivisions 2, 8; 256J.45, subdivision 2; 256L.03, subdivisions 1, 1a, 5; 256L.11, subdivision 7, by adding a subdivision; 256L.15, subdivision 2; 256P.06, subdivision 2; 256P.07, subdivisions 3, 6; 256R.02, subdivisions 4, 17, 18, 19, 22, 42, 52, by adding

subdivisions; 256R.06, subdivision 5; 256R.07, by adding a subdivision; 256R.10, by adding a subdivision; 256R.37; 256R.40, subdivisions 1, 5; 256R.41; 256R.47; 256R.49, subdivision 1; 260C.451, subdivision 6; 327.15, subdivision 3; 364.09; 609.5315, subdivision 5c; 626.556, subdivisions 2, 3, 3c, 4, 10d, 10e, 10f, 10i; Laws 2009, chapter 101, article 1, section 12; Laws 2012, chapter 247, article 4, section 47, as amended; article 6, section 2, subdivision 2; Laws 2013, chapter 108, article 15, section 2, subdivision 2; Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended; Laws 2017, chapter 2, article 1, sections 2, subdivision 3; 5; 7; Laws 2017, chapter 13, article 1, section 15; proposing coding for new law in Minnesota Statutes, chapters 103I; 119B; 137; 144; 147A; 148; 245; 245A; 256; 256B; 256I; 256N; 256R; proposing coding for new law as Minnesota Statutes, chapters 144H; 245G; repealing Minnesota Statutes 2016, sections 13.468; 103I.005, subdivisions 8, 14, 15; 103I.451; 119B.07; 144.0571; 144A.351, subdivision 2; 147A.21; 147B.08, subdivisions 1, 2, 3; 147C.40, subdivisions 1, 2, 3, 4; 148.6402, subdivision 2; 148.6450; 148.906; 148.907, subdivision 5; 148.908; 148.909, subdivision 7; 148.96, subdivisions 4, 5; 245A.1915; 245A.192; 254A.02, subdivision 4; 256B.19, subdivision 1c; 256B.4914, subdivision 16; 256B.64; 256B.7631; Laws 2012, chapter 247, article 4, section 47, as amended; Laws 2015, chapter 71, article 7, section 54; Minnesota Rules, parts 5600.2500; 9500.1140, subparts 3, 4, 5, 6; 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500; 9530.6505.

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

ARTICLE 1

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2016, section 144A.351, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

Sec. 2. Minnesota Statutes 2016, 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, 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, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan; ~~and~~

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only; and

(7) individual community living support under section 256B.0915, subdivision 3j.

(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 support services as defined under the brain injury and community access for disability inclusion waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans; ~~and~~

(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;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community 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) 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 training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental disability waiver plan; and

(iii) prevocational services as defined under the brain injury and community access for disability inclusion waiver plans; and

(5) ~~supported employment as defined under the brain injury, developmental disability, and community access for disability inclusion waiver plans~~ employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans.

EFFECTIVE DATE. (a) The amendment to paragraphs (b) and (c), clause (2), is effective the day following final enactment.

(b) The amendments to paragraph (c), clauses (5) to (7), are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2016, 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, ~~and supported employment,~~ center-based work-related activities, or other community-integrated activities designed and implemented in accordance with the individual service and individual habilitation plans required under

Minnesota Rules, parts 9525.0004 to 9525.0036, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community; and

(2) are provided by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, 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 upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. **[256.477] SELF-ADVOCACY GRANTS.**

(a) The commissioner shall make available a grant for the purposes of establishing and maintaining a statewide self-advocacy network for persons with intellectual and developmental disabilities. The self-advocacy network shall:

(1) ensure that persons with intellectual and developmental disabilities are informed of their rights in employment, housing, transportation, voting, government policy, and other issues pertinent to the intellectual and developmental disability community;

(2) provide public education and awareness of the civil and human rights issues persons with intellectual and developmental disabilities face;

(3) provide funds, technical assistance, and other resources for self-advocacy groups across the state; and

(4) organize systems of communications to facilitate an exchange of information between self-advocacy groups.

(b) An organization receiving a grant under paragraph (a) must be an organization governed by people with intellectual and developmental disabilities that administers a statewide network of disability groups in order to maintain and promote self-advocacy

services and supports for persons with intellectual and developmental disabilities throughout the state.

Sec. 5. Minnesota Statutes 2016, section 256B.0625, subdivision 6a, is amended to read:

Subd. 6a. **Home health services.** Home health services are those services specified in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance covers home health services at a recipient's home residence or in the community where normal life activities take the recipient. Medical assistance does not cover home health services for residents of a hospital, nursing facility, or intermediate care facility, unless the commissioner of human services has authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with developmental disabilities, to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to sections 256B.0651 to 256B.0653.

Sec. 6. Minnesota Statutes 2016, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

Sec. 7. Minnesota Statutes 2016, section 256B.0653, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Assessment" means an evaluation of the recipient's medical need for home health agency services by a registered nurse or appropriate therapist that is conducted within 30 days of a request.

(b) "Home care therapies" means occupational, physical, and respiratory therapy and speech-language pathology services provided in the home by a Medicare certified home health agency.

(c) "Home health agency services" means services delivered ~~in the recipient's home residence, except as specified in section 256B.0625,~~ by a home health agency to a recipient with medical needs due to illness, disability, or physical conditions in settings permitted under section 256B.0625, subdivision 6a.

(d) "Home health aide" means an employee of a home health agency who completes medically oriented tasks written in the plan of care for a recipient.

(e) "Home health agency" means a home care provider agency that is Medicare-certified.

(f) "Occupational therapy services" mean the services defined in Minnesota Rules, part 9505.0390.

(g) "Physical therapy services" mean the services defined in Minnesota Rules, part 9505.0390.

(h) "Respiratory therapy services" mean the services defined in chapter 147C.

(i) "Speech-language pathology services" mean the services defined in Minnesota Rules, part 9505.0390.

(j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks required due to a recipient's medical condition that can only be safely provided by a professional nurse to restore and maintain optimal health.

(k) "Store-and-forward technology" means telehomecare services that do not occur in real time via synchronous transmissions such as diabetic and vital sign monitoring.

(l) "Telehomecare" means the use of telecommunications technology via live, two-way interactive audiovisual technology which may be augmented by store-and-forward technology.

(m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to deliver a skilled nurse visit to a recipient located at a site other than the site where the nurse is located and is used in combination with face-to-face skilled nurse visits to adequately meet the recipient's needs.

Sec. 8. Minnesota Statutes 2016, section 256B.0653, subdivision 3, is amended to read:

Subd. 3. **Home health aide visits.** (a) Home health aide visits must be provided by a certified home health aide using a written plan of care that is updated in compliance with Medicare regulations. A home health aide shall provide hands-on personal care, perform simple procedures as an extension of therapy or nursing services, and assist in instrumental activities of daily living as defined in section 256B.0659, including assuring that the person gets to medical appointments if identified in the written plan of care. Home health aide visits ~~must~~ may be provided in the recipient's home or in the community where normal life activities take the recipient.

(b) All home health aide visits must have authorization under section 256B.0652. The commissioner shall limit home health aide visits to no more than one visit per day per recipient.

(c) Home health aides must be supervised by a registered nurse or an appropriate therapist when providing services that are an extension of therapy.

Sec. 9. Minnesota Statutes 2016, section 256B.0653, subdivision 4, as amended by Laws 2017, chapter 59, section 10, is amended to read:

Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse, according to the written plan of care and accepted standards of medical and nursing practice according to chapter 148. Skilled nurse visit services must be ordered by a physician, advanced practice registered nurse, or physician assistant and documented in a plan of care that is reviewed and approved by the ordering physician, advanced practice registered nurse, or physician assistant at least once every 60 days. All skilled nurse visits must be medically necessary and provided in the recipient's home residence or in the community where normal life activities take the recipient, except as allowed under section 256B.0625, subdivision 6a.

(b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of up to two visits per day per recipient. All visits must be based on assessed needs.

(c) Telehomecare skilled nurse visits are allowed when the recipient's health status can be accurately measured and assessed without a need for a face-to-face, hands-on encounter. All telehomecare skilled nurse visits must have authorization and are paid at the same allowable rates as face-to-face skilled nurse visits.

(d) The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Individually identifiable patient data obtained through real-time or store-and-forward technology must be maintained as health records according to sections 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed.

(e) Authorization for skilled nurse visits must be completed under section 256B.0652. A total of nine face-to-face skilled nurse visits per calendar year do not require authorization. All telehomecare skilled nurse visits require authorization.

Sec. 10. Minnesota Statutes 2016, section 256B.0653, subdivision 5, is amended to read:

Subd. 5. **Home care therapies.** (a) Home care therapies include the following: physical therapy, occupational therapy, respiratory therapy, and speech and language pathology therapy services.

(b) Home care therapies must be:

(1) provided in the recipient's residence or in the community where normal life activities take the recipient after it has been determined the recipient is unable to access outpatient therapy;

(2) prescribed, ordered, or referred by a physician and documented in a plan of care and reviewed, according to Minnesota Rules, part 9505.0390;

(3) assessed by an appropriate therapist; and

(4) provided by a Medicare-certified home health agency enrolled as a Medicaid provider agency.

(c) Restorative and specialized maintenance therapies must be provided according to Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

(d) For both physical and occupational therapies, the therapist and the therapist's assistant may not both bill for services provided to a recipient on the same day.

Sec. 11. Minnesota Statutes 2016, section 256B.0653, subdivision 6, is amended to read:

Subd. 6. **Noncovered home health agency services.** The following are not eligible for payment under medical assistance as a home health agency service:

(1) telehomecare skilled nurses services that is communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners;

(2) the following skilled nurse visits:

(i) for the purpose of monitoring medication compliance with an established medication program for a recipient;

(ii) administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;

(iii) services done for the sole purpose of supervision of the home health aide or personal care assistant;

(iv) services done for the sole purpose to train other home health agency workers;

(v) services done for the sole purpose of blood samples or lab draw when the recipient is able to access these services outside the home; and

(vi) Medicare evaluation or administrative nursing visits required by Medicare;

(3) home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education; ~~and~~

(4) home care therapies provided in other settings such as a clinic~~, day program,~~ or as an inpatient or when the recipient can access therapy outside of the recipient's residence; and

(5) home health agency services without qualifying documentation of a face-to-face encounter as specified in subdivision 7.

Sec. 12. Minnesota Statutes 2016, section 256B.0653, is amended by adding a subdivision to read:

Subd. 7. **Face-to-face encounter.** (a) A face-to-face encounter by a qualifying provider must be completed for all home health services regardless of the need for prior authorization, except when providing a onetime perinatal visit by skilled nursing. The face-to-face encounter may occur through telemedicine as defined in section 256B.0625, subdivision 3b. The encounter must be related to the primary reason the recipient requires home health services and must occur within the 90 days before or the 30 days after the start of services. The

face-to-face encounter may be conducted by one of the following practitioners, licensed in Minnesota:

(1) a physician;

(2) a nurse practitioner or clinical nurse specialist;

(3) a certified nurse midwife; or

(4) a physician assistant.

(b) The allowed nonphysician practitioner, as described in this subdivision, performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the recipient's medical record. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician responsible for ordering the services must:

(1) document that the face-to-face encounter, which is related to the primary reason the recipient requires home health services, occurred within the required time period; and

(2) indicate the practitioner who conducted the encounter and the date of the encounter.

(c) For home health services requiring authorization, including prior authorization, home health agencies must retain the qualifying documentation of a face-to-face encounter as part of the recipient health service record, and submit the qualifying documentation to the commissioner or the commissioner's designee upon request.

Sec. 13. Minnesota Statutes 2016, 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, 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 case management services available under sections 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

(3) determination of institutional level of care, home and community-based service waiver, and other service eligibility as required under section 256B.092, determination of

eligibility for family support grants under section 252.32, semi-independent living services under section 252.275, and day training and habilitation services under section 256B.092; and

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

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

(d) "Minnesota health care programs" means the medical assistance program under 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. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 2b, is amended to read:

Subd. 2b. **MnCHOICES certified assessors.** (a) Each lead agency shall use certified assessors who have completed MnCHOICES training and the certification processes determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate best practices in assessment and support planning including person-centered planning ~~principals~~ principles and have a common set of skills that must ensure consistency and equitable access to services statewide. ~~A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.~~ Certified assessors must use person-centered planning principles to conduct an interview that identifies what is important to the person,

the person's needs for supports, health and safety concerns, and the person's abilities, interests, and goals.

Certified assessors are responsible for:

(1) ensuring persons are offered objective, unbiased access to resources;

(2) ensuring persons have the needed information to support informed choice, including where and how they choose to live and the opportunity to pursue desired employment;

(3) determining level of care and eligibility for long-term services and supports;

(4) using the information gathered from the interview to develop a person-centered community support plan that reflects identified needs and support options within the context of values, interests, and goals important to the person; and

(5) providing the person with a community support plan that summarizes the person's assessment findings, support options, and agreed-upon next steps.

(b) MnCHOICES certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse with at least two years of home and community-based experience who has received training and certification specific to assessment and consultation for long-term care services in the state.

Sec. 15. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** 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 a review of the current 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 must be conducted annually or as required by federal and state laws and rules.

Sec. 16. Minnesota Statutes 2016, section 256B.0911, subdivision 4d, as amended by Laws 2017, chapter 40, article 1, section 69, is amended to read:

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

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

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

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

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

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within ~~40 calendar days of admission~~ the timeline established by the commissioner, based on review of data.

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

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

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

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

Sec. 17. Minnesota Statutes 2016, 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.

Sec. 18. Minnesota Statutes 2016, section 256B.0911, subdivision 6, as amended by Laws 2017, chapter 40, article 1, section 70, is amended to read:

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

(b) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year

must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(c) The commissioner shall include the total annual payment determined under paragraph (b) for each nursing facility reimbursed under section 256B.431, 256B.434, or chapter 256R.

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

(e) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

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

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

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

(i) The commissioner shall develop an alternative payment methodology, effective on October 1, 2013, for long-term care consultation services that includes the funding available under this subdivision, and for assessments authorized under sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider

the maximization of other funding sources, including federal administrative reimbursement through federal financial participation funding, for all long-term care consultation activity. The alternative payment methodology shall include the use of the appropriate time studies and the state financing of nonfederal share as part of the state's medical assistance program. Between July 1, 2017, and June 30, 2019, the state shall pay 84.3 percent of the nonfederal share as reimbursement to the counties. Beginning July 1, 2019, the state shall pay 81.9 percent of the nonfederal share as reimbursement to the counties.

Sec. 19. Minnesota Statutes 2016, section 256B.0921, is amended to read:

256B.0921 HOME AND COMMUNITY-BASED SERVICES INCENTIVE 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. ~~The initial requests for proposals must be issued by October 1, 2016.~~

Sec. 20. Minnesota Statutes 2016, 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. (a) The amendment to paragraph (b) is effective the day following final enactment.

(b) The amendment to paragraph (c) is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision to read:

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.

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

Sec. 22. Minnesota Statutes 2016, 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) "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) "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.

(e) "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) "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) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

(h) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

(i) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

(j) "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) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

(l) "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) "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) "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 prevocational services, a unit of service is a day or an hour. 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~~÷~~

~~(i) for respite services~~, a unit of service is ~~a day or~~ 15 minutes. ~~When a day rate is authorized, any portion of a calendar day when an individual receives services is billable as a day; and~~

~~(ii) for all other services, a unit of service is 15 minutes.~~

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. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 3, 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;

(3) adult day care bath;

(4) behavioral programming;

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) housing access coordination;

(9) independent living skills;

(10) in-home family support;

(11) night supervision;

(12) personal support;

(13) prevocational services;

(14) residential care services;

(15) residential support services;

(16) respite services;

(17) structured day services;

(18) supported employment services;

(19) supported living services;

(20) transportation services; ~~and~~

(21) individualized home supports;

(22) independent living skills specialist services;

(23) employment exploration services;

(24) employment development services;

(25) employment support services; and

~~(21)~~ (26) other services as approved by the federal government in the state home and community-based services plan.

EFFECTIVE DATE. (a) Clause (21) is effective the day following final enactment.

(b) Clauses (22) to (25) are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(c) Clause (18) expires upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 24. Minnesota Statutes 2016, 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 ~~aide~~ assistant (SOC code ~~31-1012~~ 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 ~~aide~~ assistant (SOC code ~~31-1012~~ 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 day services, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 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) for residential asleep-overnight staff, the wage ~~will be $7.66 per hour~~ is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is ~~$2.80 per hour~~ 36 percent of the minimum wage in Minnesota for large employers;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

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

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 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) for housing access coordination staff, ~~50~~ 100 percent of the median wage for community and social services specialist (SOC code 21-1099); ~~and 50 percent of the median wage for social and human services aide (SOC code 21-1093);~~

(9) for in-home family support 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) for individualized home supports 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) 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);

~~(11)~~ (13) for supported employment staff, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 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) 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) 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) 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);

~~(12)~~ (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 ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(13)~~ (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 ~~aide~~ assistant (SOC code ~~31-1012~~ 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);

~~(14)~~ (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 ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(15)~~ (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 ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(16)~~ (21) for supervisory staff, ~~the basic wage is $17.43 per hour~~, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of behavior professional, behavior analyst, and behavior specialists, which ~~must be $30.75 per hour~~ is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

~~(17)~~ (22) for registered nurse staff, ~~the basic wage is $30.82 per hour~~, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

~~(18)~~ (23) for licensed practical nurse staff, ~~the basic wage is $18.64 per hour~~ 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

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

(c) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: ~~3.9~~ 9.4 percent.

(e) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: ~~3.1~~ 15.5 percent;

(5) client programming and supports ratio: ~~8.6~~ 4.7 percent;

(6) general administrative support ratio: 13.25 percent;

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

(8) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: ~~3.1~~ 7.0 percent;

(5) client programming and support ratio: ~~8.6~~ 2.3 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: ~~6.1~~ 2.9 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: ~~6.1~~ 2.9 percent; and

(6) 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. ~~This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on December 31 of the calendar year five years prior.~~ On July 1, 2022, and every five 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. The commissioner shall publish these updated values and load them into the rate management system.

(i) On July 1, 2017, the commissioner shall update the framework components in ~~paragraphs (b) to (g)~~ 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. ~~This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.~~ On July 1, 2022, and every five years thereafter, 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 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 prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(j) 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. (a) The amendments to paragraphs (a) to (g) are effective January 1, 2018, except the amendment to paragraph (a), clauses (3), (21), and (22), and paragraph (d), clause (8), which are effective January 1, 2019, and the amendment to paragraph (a), clause (10), which is effective the day following final enactment.

(b) The amendments to paragraphs (h) to (j) are effective the day following final enactment.

(c) Paragraph (a), clause (13), expires upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 25. Minnesota Statutes 2016, 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:

(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) 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). This is defined as the customized direct-care rate;

(4) 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) 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), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

(6) combine the results of clauses (4) and (5), 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). This is defined as the direct staffing cost;

(7) 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);

(8) for client programming and supports, the commissioner shall add $2,179; and

(9) 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) The total rate must be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7);

(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) 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.

(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 (c), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.

(e) 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.

Sec. 26. Minnesota Statutes 2016, 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, day treatment and habilitation, 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) 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). This is defined as the customized direct-care rate;

(4) 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) 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), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

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

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

(10) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15 minute unit;

(12) this is the subtotal rate;

(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(16) 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) 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.

Sec. 27. Minnesota Statutes 2016, 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, housing access coordination, 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 ~~supported~~ employment support 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) 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). This is defined as the customized direct-care rate;

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

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

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

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for supported employment provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed three. For employment support services provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed six. For independent living skills training and individualized home supports provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and

(14) adjust the result of clause (13) 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 the day following final enactment. Supported employment services in this subdivision expire upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 28. Minnesota Statutes 2016, 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 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) 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). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

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

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of day units of service to meet an individual's needs;

(14) 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;

(15) 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). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; and

(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Sec. 29. Minnesota Statutes 2016, 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, 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) 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 ~~for day services~~;

~~(2) values for transportation rates in residential services;~~

~~(3)~~ (2) values for services where monitoring technology replaces staff time;

~~(4)~~ (3) values for indirect services;

~~(5)~~ (4) values for nursing;

~~(6) component values for independent living skills;~~

~~(7) component values for family foster care that reflect licensing requirements;~~

~~(8) adjustments to other components to replace the budget neutrality factor;~~

~~(9) remote monitoring technology for nonresidential services;~~

~~(10) values for basic and intensive services in residential services;~~

~~(11)~~ (5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

~~(12)~~ (6) values for workers' compensation as part of employee-related expenses;

~~(13)~~ (7) values for unemployment insurance as part of employee-related expenses;

~~(14) a component value to reflect costs for individuals with rates previously adjusted for the inclusion of group residential housing rate 3 costs, only for any individual enrolled as of December 31, 2013; and~~

~~(15)~~ (8) any changes in state or federal law with ~~an~~ a direct impact on the underlying cost of providing home and community-based services~~.~~; and

(9) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section.

(e) 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) 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, ~~2019~~ 2020, with another full report, and a full report once every four years thereafter.

~~(f) Based on the commissioner's evaluation of the information and data collected in paragraphs (b) to (d), the commissioner shall make recommendations to the legislature by January 15, 2015, to address any issues identified during the first year of implementation. After January 15, 2015, the commissioner may make recommendations to the legislature to address potential issues.~~

~~(g)~~ (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. Beginning July 1, 2017, the commissioner shall renew analysis and implement changes to the regional adjustment factors when adjustments required under subdivision 5, paragraph (h), occur. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

~~(h)~~ (g) 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.

~~(i) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a methodology sufficient to determine the shared staffing levels necessary to meet, at a minimum, health and welfare needs of individuals who will be living together in shared residential settings, and the required shared staffing activities described in subdivision 2, paragraph (l). This determination methodology must ensure~~

~~staffing levels are adaptable to meet the needs and desired outcomes for current and prospective residents in shared residential settings.~~

~~(j)~~ (h) 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, the commissioner shall collect transportation and trip information for all day services through the rates management system.

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

Sec. 30. Minnesota Statutes 2016, section 256B.4914, is amended by adding a subdivision 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, 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, 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. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (e). 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, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

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

Sec. 31. Minnesota Statutes 2016, section 256B.4914, subdivision 16, is amended to read:

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate

information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

(c) A service rate developed using values in subdivision 5, paragraph (a), clause (10), is not subject to budget neutrality adjustments.

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

Sec. 32. Minnesota Statutes 2016, section 256C.21, is amended to read:

256C.21 DEAF AND HARD-OF-HEARING SERVICES ACT; CITATION.

Sections 256C.21 to ~~256C.26~~ 256C.30 may be cited as the "Deaf and Hard-of-Hearing Services Act."

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

Sec. 33. Minnesota Statutes 2016, section 256C.23, subdivision 1, is amended to read:

Subdivision 1. **Scope.** For the purposes of sections 256C.21 to ~~256C.26~~ 256C.30, the terms defined in this section shall have the meanings given them, unless the context clearly indicates otherwise.

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

Sec. 34. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

Subd. 1a. **Culturally affirmative services.** "Culturally affirmative services" means services that are designed and delivered within the context of the culture, language, and life experience of a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing.

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

Sec. 35. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

Subd. 2. **Deaf.** "Deaf" means a hearing loss of such severity that the individual must depend primarily on visual communication such as writing, lip reading, ~~manual communication, and~~ American Sign Language or other signed languages, visual and manual means of communication such as signing systems in English or Cued Speech, or gestures.

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

Sec. 36. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

Subd. 2c. **Interpreting services.** "Interpreting services" means services that include:

(1) interpreting between a spoken language such as English and a visual language such as American Sign Language;

(2) interpreting between a spoken language and a visual representation of a spoken language such as Cued Speech and signing systems in English;

(3) interpreting within one language where the interpreter uses natural gestures and silently repeats the spoken message, replacing some words or phrases to give higher visibility on the lips; and

(4) interpreting using low vision or tactile methods for people who have a combined hearing and vision loss or are deafblind.

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

Sec. 37. Minnesota Statutes 2016, section 256C.233, subdivision 1, is amended to read:

Subdivision 1. **Deaf and Hard-of-Hearing Services Division.** The ~~commissioners~~ commissioner of human services~~, education, employment and economic development, and health~~ shall create ~~a distinct and separate~~ an organizational unit to be known as the Deaf and Hard-of-Hearing Services Division to address the developmental, social, ~~educational, and occupational~~ mental health, communication access, and human service needs of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ through a statewide network of ~~collaborative~~ services and by ~~coordinating the promulgation of~~ implementing public policies, regulations, legislation, services, and programs affecting persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~. ~~An interdepartmental management team shall advise the activities of the Deaf and Hard-of-Hearing Services Division.~~ The commissioner of human services shall ~~coordinate the work of the interagency management team and~~ receive legislative appropriations for the division.

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

Sec. 38. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** The Deaf and Hard-of-Hearing Services Division shall:

(1) establish and maintain a statewide network of ~~regional service centers~~ culturally affirmative services for Minnesotans who are deaf, Minnesotans who are deafblind, and Minnesotans who are hard-of-hearing ~~Minnesotans~~;

(2) assist ~~the Departments of Human Services, Education, and Employment and Economic Development~~ other state agencies to coordinate the promulgation and implementation of public policies, regulations, ~~legislation,~~ programs, and services affecting persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~; ~~and~~

(3) ~~provide a coordinated system of statewide interpreting or interpreter referral services~~ oversee and manage grant-funded services for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing and a person's family as provided in sections 237.23, 256C.25, 256C.261, 256C.30 and as appropriated by the legislature; and

(4) meet as a team with the commissioners of education, employment and economic development, and health or the commissioners' designees at least three times per year to coordinate the promulgation and implementation of public policies, regulations, programs, and services affecting persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing.

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

Sec. 39. Minnesota Statutes 2016, section 256C.233, subdivision 4, is amended to read:

Subd. 4. **State commissioners.** The commissioners of all state agencies shall consult with the Deaf and Hard-of-Hearing Services Division concerning the promulgation of public policies, regulations, and programs necessary to address the needs of Minnesotans who are deaf, Minnesotans who are deafblind, and Minnesotans who are hard-of-hearing ~~Minnesotans~~. Each state agency shall consult with the Deaf and Hard-of-Hearing Services Division concerning the need to forward legislative initiatives to the governor to address the concerns of Minnesotans who are deaf, Minnesotans who are deafblind, and Minnesotans who are hard-of-hearing ~~Minnesotans~~.

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

Sec. 40. Minnesota Statutes 2016, section 256C.24, is amended to read:

256C.24 REGIONAL ~~SERVICE CENTERS~~ SERVICES.

Subdivision 1. **Location.** The Deaf and Hard-of-Hearing Services Division shall establish ~~up to eight regional service centers~~ statewide services for people who are deaf ~~and~~, people who are deafblind, and people who are hard-of-hearing ~~persons~~. The ~~centers~~ services shall be distributed regionally to provide access for people who are deaf, people who are deafblind, and people who are hard-of-hearing ~~persons~~ in all parts of the state.

Subd. 2. **Responsibilities.** ~~Each regional service center~~ The Deaf and Hard-of-Hearing Services Division shall:

(1) ~~serve as a central entry point for deaf, deafblind, and hard-of-hearing persons in need of services and make referrals to the services needed~~ provide culturally affirmative direct assistance to a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing and the person's family to improve the person's communication access and quality of life at home and in the community. Direct assistance may be provided using technology only in areas of the state when a person has access to sufficient quality telecommunications or broadband services to allow effective communication. When a person who is deaf, a person who is deafblind, or a person who is hard-of-hearing only has access to insufficient telecommunications or broadband service, direct assistance shall be available in person. Direct assistance may include:

(i) teaching communication strategies and coping skills;

(ii) offering guidance and problem solving assistance;

(iii) making referrals related to enhancing a person's independence;

(iv) providing information and assistance to support the person's ability to be self-sufficient and live independently; and

(v) identifying technology solutions to improve access to communication and to environmental information;

(2) employ staff trained to work with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~;

~~(3) provide to all deaf, deafblind, and hard-of-hearing persons access to interpreter services which are necessary to help them obtain services;~~

~~(4) implement a plan to provide loaned equipment and resource materials to deaf, deafblind, and hard-of-hearing persons;~~

~~(5) cooperate with~~ (3) advise responsible departments and administrative authorities ~~to provide~~ about providing access for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ to services provided by state, county, ~~and~~ regional and local agencies;

~~(6) collaborate with the Resource Center for the Deaf and Hard-of-Hearing Persons, other divisions of the Department of Education, and local school districts to develop and deliver programs and services for families with deaf, deafblind, or hard-of-hearing children and to support school personnel serving these children;~~

~~(7) when possible, provide training to the social service or income maintenance staff employed by counties or by organizations with whom counties contract for services to ensure that communication barriers which prevent deaf, deafblind, and hard-of-hearing persons from using services are removed;~~

~~(8) when possible, provide training to state and regional human service agencies regarding program access for deaf, deafblind, and hard-of-hearing persons; and~~

(4) provide training and technical assistance to county, state, regional, and local agencies, and others on hearing loss, deaf culture, assistive technology, and other related topics to ensure that programs and services are accessible to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing;

(5) provide training to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing to develop the skills and knowledge needed to advocate for communication access and service needs;

~~(9)~~ (6) assess the ongoing need and supply of services for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ in all parts of the state and cooperate with public and private service providers to develop these services.

(7) provide culturally affirmative mental health services for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing;

(8) provide telecommunications devices to a Minnesotan with a communication disability according to sections 237.51 to 237.56; and

(9) assess requests from provisionally certified educational interpreters and transliterators for onetime limited certification extensions according to section 122A.31.

Subd. 3. **Advisory committee.** The director of the Deaf and Hard-of-Hearing Services Division shall appoint ~~an advisory committee~~ eight advisory committees of up to nine persons ~~for each regional service area~~ per advisory committee. Each committee shall represent a specific region of the state. The director shall determine the boundaries of each advisory committee region. The committees shall advise the director on the needs of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing and service gaps in the region of the state the committee represents. Members shall include persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, persons who have communication disabilities, parents of children who are deaf and parents of children who are hard-of-hearing, parents of children who have communication disabilities, and representatives of county and regional human services, including representatives of private service providers. At least 50 percent of the members must be deaf or deafblind or hard-of-hearing or have a communication disability. Committee members shall serve for a three-year term ~~and shall serve no more than two consecutive terms~~, and may be appointed to consecutive terms. Each advisory committee shall elect a chair. The director of the Deaf and Hard-of-Hearing Services Division shall assign staff to serve as nonvoting members of the committee. Members shall not receive a per diem. Otherwise, the compensation, removal of members, and filling of vacancies on the committee shall be as provided in section 15.0575.

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

Sec. 41. Minnesota Statutes 2016, section 256C.25, subdivision 1, is amended to read:

Subdivision 1. ~~**Establishment**~~ **Duties.** (a) The Deaf and Hard-of-Hearing Services Division shall maintain ~~and coordinate statewide interpreting or interpreter referral services for~~ a statewide information source about available interpreting services for a person who is

deaf, a person who is deafblind, and a person who is hard-of-hearing. The information source shall be available for use by any public or private agency or individual in the state.

(b) The division shall identify areas of the state where there are shortages of qualified interpreting services and develop strategies for addressing the shortages. The division shall directly coordinate these services but may contract with an appropriate agency to ~~provide this service~~ implement the strategies. ~~The division may collect a $3 fee per referral for interpreter referral services and the actual costs of interpreter services provided by department staff. Fees and payments collected shall be deposited in the general fund. The $3 referral fee shall not be collected from state agencies or local units of government or deaf or hard-of-hearing consumers or interpreters.~~

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

Sec. 42. Minnesota Statutes 2016, section 256C.261, is amended to read:

256C.261 SERVICES FOR A PERSON WHO IS DEAFBLIND ~~PERSONS~~.

(a) ~~The commissioner of human services shall combine the existing biennial base level funding for deafblind services into a single grant program. At least 35 percent of the total funding is awarded for services and other supports to deafblind children and their families and at least 25 percent is awarded for services and other supports to deafblind adults.~~ The commissioner of human services shall use at least 35 percent of the deafblind services biennial base level grant funding for services and other supports for a child who is deafblind and the child's family. The commissioner shall use at least 25 percent of the deafblind services biennial base level grant funding for services and other supports for an adult who is deafblind.

The commissioner shall award grants for the purposes of:

(1) providing services and supports to individuals who are deafblind; and

(2) developing and providing training to counties and the network of senior citizen service providers. The purpose of the training grants is to teach counties how to use existing programs that capture federal financial participation to meet the needs of eligible deafblind persons and to build capacity of senior service programs to meet the needs of seniors with a dual sensory hearing and vision loss.

(b) The commissioner may make grants:

(1) for services and training provided by organizations; and

(2) to develop and administer consumer-directed services.

(c) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under paragraph (a).

(d) Deafblind service providers may, but are not required to, provide ~~intervenor~~ intervener services as part of the service package provided with grant funds under this section.

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

Sec. 43. Minnesota Statutes 2016, section 256C.30, is amended to read:

256C.30 DUTIES OF HUMAN SERVICES COMMISSIONER.

(a) As described in this section, the commissioner of human services must enter into grant agreements with television stations to make live local news programming accessible to persons who are deaf, persons who are hard-of-hearing, and persons who are deafblind ~~persons~~ as defined in section 256C.23.

(b) The grant agreements must provide for:

(1) real-time captioning services for broadcasting that is not emergency broadcasting subject to Code of Federal Regulations, title 47, section 79.2;

(2) real-time captioning services for commercial broadcasters in areas of Minnesota where commercial broadcasters are not subject to the live programming closed-captioning requirements of Code of Federal Regulations, title 47, section 79.1(d); and

(3) real-time captioning for large-market noncommercial broadcasters who produce live news programming.

(c) For the purposes of this section, "real-time captioning" means a method of captioning in which captions are simultaneously prepared and transmitted at the time of origination by specially trained real-time captioners.

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

Sec. 44. Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter 312, article 27, section 72, and Laws 2016, chapter 144, section 1, the effective date, is amended to read:

EFFECTIVE DATE. ~~The amendments to this section are effective on June 1, 2016, and expire on the date Laws 2015, chapter 71, article 7, section 54, becomes effective. The commissioner of human services shall notify the revisor of statutes when Laws 2015, chapter 71, article 7, section 54, becomes effective.~~ Notwithstanding any other law to the contrary, the exception in this section is effective until the exception under section 44 or under Laws

2015, chapter 71, article 7, section 54, becomes effective, whichever occurs first. The commissioner of human services shall notify the revisor of statutes when section 44 or Laws 2015, chapter 71, article 7, section 54, is effective.

Sec. 45. **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); 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.

EFFECTIVE DATE. The exception under this section is effective October 1, 2017, or upon federal approval, whichever is later. Notwithstanding any other law to the contrary, the exception in Laws 2016, chapter 144, section 1, remains in effect until the exception under Laws 2015, chapter 71, article 7, section 54, or under this section becomes effective, whichever occurs first. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 46. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY 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.

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

Sec. 47. **CONSUMER-DIRECTED COMMUNITY SUPPORTS REVISED BUDGET METHODOLOGY REPORT.**

(a) The commissioner of human services, in consultation with stakeholders and others including representatives of lead agencies, home and community-based services waiver participants using consumer-directed community supports, advocacy groups, state agencies,

the Institute on Community Integration at the University of Minnesota, and service and financial management providers, shall develop a revised consumer-directed community supports budget methodology. The new methodology shall be based on (1) the costs of providing services as reflected by the wage and other relevant components incorporated in the disability waiver rate formulas under Minnesota Statutes, chapter 256B, and (2) state-to-county waiver-funding methodologies. The new methodology should develop individual consumer-directed community supports budgets comparable to those provided for similar needs individuals if paying for non-consumer-directed community supports waiver services.

(b) By December 15, 2018, the commissioner shall report a revised consumer-directed community supports budget methodology, including proposed legislation and funding necessary to implement the new methodology, to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services.

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

Sec. 48. **FEDERAL WAIVER AMENDMENTS.**

The commissioner of human services shall submit necessary waiver amendments to the Centers for Medicare and Medicaid Services to add employment exploration services, employment development services, and employment support services to the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49. The commissioner shall also submit necessary waiver amendments to remove community-based employment services from day training and habilitation and prevocational services. The commissioner shall submit all necessary waiver amendments by October 1, 2017.

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

Sec. 49. **TRANSPORTATION STUDY.**

The commissioner of human services, with cooperation from lead agencies and in consultation with stakeholders, shall conduct a study to identify opportunities to increase access to transportation services for an individual who receives home and community-based services. The commissioner shall submit a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by January 15, 2019. The report shall:

(1) study all aspects of the current transportation service network, including the fleet available, the different rate-setting methods currently used, methods that an individual uses to access transportation, and the diversity of available provider agencies;

(2) identify current barriers for an individual accessing transportation and for a provider providing waiver services transportation in the marketplace;

(3) identify efficiencies and collaboration opportunities to increase available transportation, including transportation funded by medical assistance, and available regional transportation and transit options;

(4) study transportation solutions in other states for delivering home and community-based services;

(5) study provider costs required to administer transportation services;

(6) make recommendations for coordinating and increasing transportation accessibility across the state; and

(7) make recommendations for the rate setting of waivered transportation.

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

Sec. 50. **DIRECTION TO COMMISSIONER; MnCHOICES ASSESSMENT TOOL.**

The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services under Minnesota Statutes, section 256B.0911, to modify the MnCHOICES assessment tool and related policies to:

(1) reduce assessment times;

(2) create efficiencies within the tool and within practice and policy for conducting assessments and support planning;

(3) implement policy changes reducing the frequency and depth of assessment and reassessment, while ensuring federal compliance with medical assistance and disability waiver eligibility requirements; and

(4) evaluate alternative payment methods.

Sec. 51. **RANDOM MOMENT TIME STUDY EVALUATION REQUIRED.**

The commissioner of human services shall implement administrative efficiencies and evaluate the random moment time study methodology for reimbursement of costs associated with county duties required under Minnesota Statutes, section 256B.0911. The study must

determine whether random moment is efficient and effective in supporting functions of assessment and support planning and the purpose under Minnesota Statutes, section 256B.0911, subdivision 1. The commissioner shall submit a report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services by January 15, 2019. The report must provide recommendations for changes to payment methodologies and functions related to assessment, eligibility determination, and support planning.

Sec. 52. **RATE INCREASE FOR SELF-DIRECTED WORKFORCE NEGOTIATIONS.**

(a) Notwithstanding any other law or rule to the contrary, effective July 1, 2017, and within available appropriations, the commissioner of human services shall have the authority to implement rate adjustments to comply with wages and benefits negotiated in the labor agreement between the state of Minnesota and the Service Employees International Union (SEIU) Healthcare Minnesota for the period between July 1, 2017, and June 30, 2019.

(b) The rate changes described in this section apply to direct support services provided through a covered program, as defined by Minnesota Statutes, section 256B.0711, subdivision 1, paragraph (b).

Sec. 53. **REPEALER.**

(a) Minnesota Statutes 2016, section 144A.351, subdivision 2, is repealed.

(b) Minnesota Statutes 2016, section 256B.4914, subdivision 16, is repealed effective January 1, 2018.

(c) Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter 312, article 27, section 72, Laws 2015, chapter 71, article 7, section 58, Laws 2016, chapter 144, section 1; and Laws 2015, chapter 71, article 7, section 54, are repealed upon the effective date of section 44.

ARTICLE 2

HOUSING

Section 1. Minnesota Statutes 2016, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a description of the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of ~~residents~~ a resident to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

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

Sec. 2. Minnesota Statutes 2016, section 144D.04, is amended by adding a subdivision to read:

Subd. 2a. **Additional contract requirements.** (a) For a resident receiving one or more health-related services from the establishment's arranged home care provider, as defined in section 144D.01, subdivision 6, the contract must include the requirements in paragraph (b). A restriction of a resident's rights under this subdivision is allowed only if determined necessary for health and safety reasons identified by the home care provider's registered nurse in an initial assessment or reassessment, as defined under section 144A.4791, subdivision 8, and documented in the written service plan under section 144A.4791, subdivision 9. Any restrictions of those rights for people served under sections 256B.0915 and 256B.49 must be documented in the resident's coordinated service and support plan (CSSP), as defined under sections 256B.0915, subdivision 6 and 256B.49, subdivision 15.

(b) The contract must include a statement:

(1) regarding the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) regarding the resident's right to access food at any time;

(3) regarding a resident's right to choose the resident's visitors and times of visits;

(4) regarding the resident's right to choose a roommate if sharing a unit; and

(5) notifying the resident of the resident's right to have and use a lockable door to the resident's unit. The landlord shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

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

Sec. 3. Minnesota Statutes 2016, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; ~~or~~

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal;

(6) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from the residential care waiver services to foster care services. This exception applies only when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service to help the person make an informed choice; and

(ii) the person's foster care services are less than or equal to the cost of the person's services delivered in the residential care waiver service setting as determined by the lead agency; or

(7) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(ii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the unlicensed setting as determined by the lead agency.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately

inform the Department of Human Services Licensing Division. The department ~~shall~~ may decrease the statewide licensed capacity for adult foster care settings ~~where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Prior to any involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies and license holders to determine which adult foster care settings, where the physical location is not the primary residence of the license holder, or community residential settings, are licensed for up to five beds, but have operated at less than full capacity for 12 or more months as of March 1, 2014. The settings that meet these criteria must be the first to be considered for an involuntary decrease in statewide licensed capacity, up to a maximum of 35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall prioritize the selection of those beds to be closed based on the length of time the beds have been vacant. The longer a bed has been vacant, the higher priority it must be given for closure. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program, or the community residential settings, to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter~~.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity ~~required~~ determined under ~~paragraph (c)~~ section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate

foster care or community residential settings, long-term ~~care~~ service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term ~~care~~ services and supports reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data and targets on ~~the overall~~ capacity of licensed long-term ~~care~~ services and supports, actions taken under this subdivision to manage statewide long-term ~~care~~ services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must

inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

Sec. 4. Minnesota Statutes 2016, section 245A.04, subdivision 14, is amended to read:

Subd. 14. **Policies and procedures for program administration required and enforceable.** (a) The license holder shall develop program policies and procedures necessary to maintain compliance with licensing requirements under Minnesota Statutes and Minnesota Rules.

(b) The license holder shall:

(1) provide training to program staff related to their duties in implementing the program's policies and procedures developed under paragraph (a);

(2) document the provision of this training; and

(3) monitor implementation of policies and procedures by program staff.

(c) The license holder shall keep program policies and procedures readily accessible to staff and index the policies and procedures with a table of contents or another method approved by the commissioner.

(d) An adult foster care license holder that provides foster care services to a resident under section 256B.0915 must annually provide a copy of the resident termination policy under section 245A.11, subdivision 11, to a resident covered by the policy.

Sec. 5. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 9. **Adult foster care bedrooms.** (a) A resident receiving services must have a choice of roommate. Each roommate must consent in writing to sharing a bedroom with one another. The license holder is responsible for notifying a resident of the resident's right to request a change of roommate.

(b) The license holder must provide a lock for each resident's bedroom door, unless otherwise indicated for the resident's health, safety, or well-being. A restriction on the use of the lock must be documented and justified in the resident's individual abuse prevention plan required by sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14.For a resident served under section 256B.0915, the case manager must be part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b).

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

Sec. 6. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 10. **Adult foster care resident rights.** (a) The license holder shall ensure that a resident and a resident's legal representative are given, at admission:

(1) an explanation and copy of the resident's rights specified in paragraph (b);

(2) a written summary of the Vulnerable Adults Protection Act prepared by the department; and

(3) the name, address, and telephone number of the local agency to which a resident or a resident's legal representative may submit an oral or written complaint.

(b) Adult foster care resident rights include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local and long-distance telephone calls made collect or paid for by the resident;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will;

(4) have privacy for visits with the resident's spouse, next of kin, legal counsel, religious adviser, or others, according to section 363A.09 of the Human Rights Act, including privacy in the resident's bedroom;

(5) keep, use, and access the resident's personal clothing and possessions as space permits, unless this right infringes on the health, safety, or rights of another resident or household member, including the right to access the resident's personal possessions at any time;

(6) choose the resident's visitors and time of visits and participate in activities of commercial, religious, political, and community groups without interference if the activities do not infringe on the rights of another resident or household member;

(7) if married, privacy for visits by the resident's spouse, and, if both spouses are residents of the adult foster home, the residents have the right to share a bedroom and bed;

(8) privacy, including use of the lock on the resident's bedroom door or unit door. A resident's privacy must be respected by license holders, caregivers, household members, and volunteers by knocking on the door of a resident's bedroom or bathroom and seeking consent before entering, except in an emergency;

(9) furnish and decorate the resident's bedroom or living unit;

(10) engage in chosen activities and have an individual schedule supported by the license holder that meets the resident's preferences;

(11) freedom and support to access food at any time;

(12) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(13) access records and recorded information about the resident according to applicable state and federal law, regulation, or rule;

(14) be free from maltreatment;

(15) be treated with courtesy and respect and receive respectful treatment of the resident's property;

(16) reasonable observance of cultural and ethnic practice and religion;

(17) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(18) be informed of and use the license holder's grievance policy and procedures, including how to contact the highest level of authority in the program;

(19) assert the resident's rights personally, or have the rights asserted by the resident's family, authorized representative, or legal representative, without retaliation; and

(20) give or withhold written informed consent to participate in any research or experimental treatment.

(c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8), (10), and (11), is allowed only if determined necessary to ensure the health, safety, and well-being of the resident. Any restriction of a resident's right must be documented and justified in the resident's individual abuse prevention plan required by sections 245A.65, subdivision 2, paragraph (b) and 626.557, subdivision 14. For a resident served under section 256B.0915, the case manager must be part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the least restrictive manner necessary to protect the resident and provide support to reduce or eliminate the need for the restriction.

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

Sec. 7. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 11. **Adult foster care service termination for elderly waiver participants.** (a) This subdivision applies to foster care services for a resident served under section 256B.0915.

(b) The foster care license holder must establish policies and procedures for service termination that promote continuity of care and service coordination with the resident and the case manager and with another licensed caregiver, if any, who also provides support to the resident. The policy must include the requirements specified in paragraphs (c) to (h).

(c) The license holder must allow a resident to remain in the program and cannot terminate services unless:

(1) the termination is necessary for the resident's health, safety, and well-being and the resident's needs cannot be met in the facility;

(2) the safety of the resident or another resident in the program is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the resident or another resident in the program;

(3) the health, safety, and well-being of the resident or another resident in the program would otherwise be endangered;

(4) the program was not paid for services;

(5) the program ceases to operate; or

(6) the resident was terminated by the lead agency from waiver eligibility.

(d) Before giving notice of service termination, the license holder must document the action taken to minimize or eliminate the need for termination. The action taken by the license holder must include, at a minimum:

(1) consultation with the resident's interdisciplinary team to identify and resolve issues leading to a notice of service termination; and

(2) a request to the case manager or other professional consultation or intervention services to support the resident in the program. This requirement does not apply to a notice of service termination issued under paragraph (c), clause (4) or (5).

(e) If, based on the best interests of the resident, the circumstances at the time of notice were such that the license holder was unable to take the action specified in paragraph (d), the license holder must document the specific circumstances and the reason the license holder was unable to take the action.

(f) The license holder must notify the resident or the resident's legal representative and the case manager in writing of the intended service termination. The notice must include:

(1) the reason for the action;

(2) except for service termination under paragraph (c), clause (4) or (5), a summary of the action taken to minimize or eliminate the need for termination and the reason the action failed to prevent the termination;

(3) the resident's right to appeal the service termination under section 256.045, subdivision 3, paragraph (a); and

(4) the resident's right to seek a temporary order staying the service termination according to the procedures in section 256.045, subdivision 4a, or subdivision 6, paragraph (c).

(g) Notice of the proposed service termination must be given at least 30 days before terminating a resident's service.

(h) After the resident receives the notice of service termination and before the services are terminated, the license holder must:

(1) work with the support team or expanded support team to develop reasonable alternatives to support continuity of care and to protect the resident;

(2) provide information requested by the resident or case manager; and

(3) maintain information about the service termination, including the written notice of service termination, in the resident's record.

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

Sec. 8. Minnesota Statutes 2016, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice;

(14) personal privacy; and

(15) engage in chosen activities.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence; and

(4) privacy for visits with the person's spouse, next of kin, legal counsel, religious ~~advisor~~ adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom~~.~~; and

(5) have access to three nutritionally balanced meals and nutritious snacks between meals each day.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

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

Sec. 9. Minnesota Statutes 2016, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a; ~~or~~

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914~~.~~<u>; or</u>

<u>(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.</u>

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case

proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), ~~clause~~ clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, ~~paragraph~~ paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

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

Sec. 10. **[256B.051] HOUSING SUPPORT SERVICES.**

Subdivision 1. **Purpose.** Housing support services are established to provide housing support services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. The services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

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

(b) "At-risk of homelessness" means (1) an individual that is faced with a set of circumstances likely to cause the individual to become homeless, or (2) an individual previously homeless, who will be discharged from a correctional, medical, mental health, or treatment center, who lacks sufficient resources to pay for housing and does not have a permanent place to live.

(c) "Commissioner" means the commissioner of human services.

(d) "Homeless" means an individual or family lacking a fixed, adequate nighttime residence.

(e) "Individual with a disability" means:

(1) an individual who is aged, blind, or disabled as determined by the criteria used by the title 11 program of the Social Security Act, United States Code, title 42, section 416, paragraph (i), item (1); or

(2) an individual who meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (5) to (9), or (14).

(f) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause (3), and the Minnesota Security Hospital as defined in section 253.20.

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing support services if the individual:

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

(3) has an assessment of functional need that determines a need for services due to limitations caused by the individual's disability;

(4) resides in or plans to transition to a community-based setting as defined in Code of Federal Regulations, title 42, section 441.301(c); and

(5) has housing instability evidenced by:

(i) being homeless or at-risk of homelessness;

(ii) being in the process of transitioning from, or having transitioned in the past six months from, an institution or licensed or registered setting;

(iii) being eligible for waiver services under section 256B.0915, 256B.092, or 256B.49; or

(iv) having been identified by a long-term care consultation under section 256B.0911 as at risk of institutionalization.

Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need must be conducted by one of the following methods:

(1) an assessor according to the criteria established in section 256B.0911, subdivision 3a, using a format established by the commissioner;

(2) documented need for services as verified by a professional statement of need as defined in section 256I.03, subdivision 12; or

(3) according to the continuum of care coordinated assessment system established in Code of Federal Regulations, title 24, section 578.3, using a format established by the commissioner.

(b) An individual must be reassessed within one year of initial assessment, and annually thereafter.

Subd. 5. **Housing support services.** (a) Housing support services include housing transition services and housing and tenancy sustaining services.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

(1) prevention and early identification of behaviors that may jeopardize continued stable housing;

(2) education and training on roles, rights, and responsibilities of the tenant and the property manager;

(3) coaching to develop and maintain key relationships with property managers and neighbors;

(4) advocacy and referral to community resources to prevent eviction when housing is at risk;

(5) assistance with housing recertification process;

(6) coordination with the tenant to regularly review, update, and modify housing support and crisis plan; and

(7) continuing training on being a good tenant, lease compliance, and household management.

(d) A housing support service may include person-centered planning for people who are not eligible to receive person-centered planning through any other service, if the person-centered planning is provided by a consultation service provider that is under contract with the department and enrolled as a Minnesota health care program.

Subd. 6. **Provider qualifications and duties.** A provider eligible for reimbursement under this section shall:

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

(2) demonstrate compliance with federal and state laws and policies for housing support services as determined by the commissioner;

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

(4) directly provide housing support services and not use a subcontractor or reporting agent.

Subd. 7. **Housing support supplemental service rates.** Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing support services under this section.

EFFECTIVE DATE. (a) Subdivisions 1 to 6 are contingent upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(b) Subdivision 7 is contingent upon federal approval of subdivisions 1 to 6. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2016, 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, 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 interview with the person being assessed and the person's legal representative. 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 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.

(e) 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, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

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

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

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

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

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, 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.

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

(j) The effective eligibility start date for programs in paragraph (i) 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 (i) cannot be prior to the date the most recent updated assessment is completed.

(k) 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 settings 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. 12. Minnesota Statutes 2016, section 256B.0915, subdivision 1, is amended to read:

Subdivision 1. **Authority.** (a) The commissioner is authorized to apply for a home and community-based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services to elderly and disabled medical assistance recipients must comply with the criteria for service definitions and provider standards approved in the waiver.

(b) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers authorized under this section.

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

Sec. 13. Minnesota Statutes 2016, section 256B.092, subdivision 4, is amended to read:

Subd. 4. **Home and community-based services for developmental disabilities.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community-based services, including case management service activities provided as an approved home and community-based service, to medical assistance eligible persons with developmental disabilities who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the federally approved application for home and community-based services for persons with developmental disabilities and subsequent amendments.

(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community-based waivered services for persons with developmental disabilities authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community-based waivered services for persons with developmental disabilities prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community-based waivered services resources based upon fiscal year 1995 authorized levels.

(c) Home and community-based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.

(d) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers for the elderly authorized under this section.

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

Sec. 14. Minnesota Statutes 2016, section 256B.49, subdivision 11, is amended to read:

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

(1) promote the support of persons with disabilities in the most integrated settings;

(2) expand the availability of services for persons who are eligible for medical assistance;

(3) promote cost-effective options to institutional care; and

(4) obtain federal financial participation.

(b) The provision of waivered services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees, task forces, the Centers for Independent Living, and others who request to be on a list to receive, notice of, and an opportunity to comment on, at least 30 days before

any effective dates, (1) any substantive changes to the state's disability services program manual, or (2) changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

(f) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers authorized under this section.

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

Sec. 15. Minnesota Statutes 2016, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Coordinated service and support plan; comprehensive transitional service plan; maintenance service 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 meets the requirements in section 256B.092, subdivision 1b.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the

comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under this section for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount

needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

~~(f) At the time of reassessment, local agency case managers shall assess each recipient of community access for disability inclusion or brain injury waivered services currently residing in a licensed adult foster 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 recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.~~

Sec. 16. Minnesota Statutes 2016, section 256B.493, subdivision 1, is amended to read:

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services ~~shall solicit proposals for the conversion of services provided for persons with disabilities in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, or community residential settings licensed under chapter 245D, to other types of community settings in conjunction with the closure of identified licensed adult foster care settings~~ has the authority to manage statewide licensed corporate foster care or community residential settings capacity, including the reduction and realignment of licensed capacity of a current foster care or community residential settings to accomplish the consolidation or closure of settings. The commissioner shall implement a program for planned closure of licensed corporate adult foster care or community residential settings, necessary as a preferred method to: (1) respond to the informed decisions of those individuals who want to move out of these settings into other types of community settings; and (2) achieve necessary budgetary savings required in section 245A.03, subdivision 7, paragraphs (c) and (d).

Sec. 17. Minnesota Statutes 2016, section 256B.493, subdivision 2, is amended to read:

Subd. 2. **Planned closure process needs determination.** ~~The commissioner shall announce and implement a program for planned closure of adult foster care homes. Planned closure shall be the preferred method for achieving necessary budgetary savings required by the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph (c). If additional closures are required to achieve the necessary savings, the commissioner shall use the process and priorities in section 245A.03, subdivision 7, paragraph (c)~~ A resource need determination process, managed at the state level, using available reports required by section 144A.351 and other data and information shall be used by the commissioner to align capacity where needed.

Sec. 18. Minnesota Statutes 2016, section 256B.493, is amended by adding a subdivision to read:

Subd. 2a. **Closure process.** (a) The commissioner shall work with stakeholders to establish a process for the application, review, approval, and implementation of setting closures. Voluntary proposals from license holders for consolidation and closure of adult foster care or community residential settings are encouraged. Whether voluntary or involuntary, all closure plans must include:

(1) a description of the proposed closure plan, identifying the home or homes and occupied beds;

(2) the proposed timetable for the proposed closure, including the proposed dates for notification to people living there and the affected lead agencies, commencement of closure, and completion of closure;

(3) the proposed relocation plan jointly developed by the counties of financial responsibility, the people living there and their legal representatives, if any, who wish to continue to receive services from the provider, and the providers for current residents of any adult foster care home designated for closure; and

(4) documentation from the provider in a format approved by the commissioner that all the adult foster care homes or community residential settings receiving a planned closure rate adjustment under the plan have accepted joint and severable for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under this plan.

(b) The commissioner shall give first priority to closure plans which:

(1) target counties and geographic areas which have:

(i) need for other types of services;

(ii) need for specialized services;

(iii) higher than average per capita use of licensed corporate foster care or community residential settings; or

(iv) residents not living in the geographic area of their choice;

(2) demonstrate savings of medical assistance expenditures; and

(3) demonstrate that alternative services are based on the recipient's choice of provider and are consistent with federal law, state law, and federally approved waiver plans.

The commissioner shall also consider any information provided by people using services, their legal representatives, family members, or the lead agency on the impact of the planned closure on people and the services they need.

(c) For each closure plan approved by the commissioner, a contract must be established between the commissioner, the counties of financial responsibility, and the participating license holder.

Sec. 19. Minnesota Statutes 2016, section 256D.44, subdivision 4, as amended by Laws 2017, chapter 59, section 12, is amended to read:

Subd. 4. **Temporary absence due to illness.** For the purposes of this subdivision, "home" means a residence owned or rented by a recipient or the recipient's spouse. ~~Home does not include a group residential housing facility.~~ Assistance payments for recipients who are temporarily absent from their home due to hospitalization for illness must continue at the same level of payment during their absence if the following criteria are met:

(1) a physician, advanced practice registered nurse, or physician assistant certifies that the absence is not expected to continue for more than three months;

(2) a physician, advanced practice registered nurse, or physician assistant certifies that the recipient will be able to return to independent living; and

(3) the recipient has expenses associated with maintaining a residence in the community.

Sec. 20. Minnesota Statutes 2016, section 256D.44, subdivision 5, as amended by Laws 2017, chapter 40, article 1, section 84, and Laws 2017, chapter 59, section 13, is amended to read:

Subd. 5. **Special needs.** (a) In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a ~~group residential~~ setting authorized to receive housing ~~facility~~ support payments under chapter 256I.

~~(a)~~ (b) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician, advanced practice registered nurse, or physician assistant. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

~~(b)~~ (c) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the

payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

~~(c)~~ (d) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

~~(d)~~ (e) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

~~(e)~~ (f) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

~~(f)~~ (g)(1) Notwithstanding the language in this subdivision, an amount equal to one-half of the maximum ~~allotment authorized by the federal Food Stamp Program for a~~ federal Supplemental Security Income payment amount for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as ~~shelter needy~~ in need of housing assistance and are:

(i) relocating from an institution, a setting authorized to receive housing support under chapter 256I, or an adult mental health residential treatment program under section 256B.0622; ~~or~~

(ii) eligible for personal care assistance under section 256B.0659; or

(iii) home and community-based waiver recipients living in their own home or rented or leased apartment.

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "~~Shelter needy~~ Housing assistance" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered ~~shelter needy~~ in need of housing assistance for purposes of this paragraph.

EFFECTIVE DATE. Paragraphs (a) to (f) are effective July 1, 2017. Paragraph (g), clause (1), is effective July 1, 2020, except paragraph (g), clause (1), items (ii) and (iii), are effective July 1, 2017.

Sec. 21. Minnesota Statutes 2016, section 256I.03, subdivision 8, is amended to read:

Subd. 8. **Supplementary services.** "Supplementary services" means housing support services provided to ~~residents of group residential housing providers~~ 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.

Sec. 22. Minnesota Statutes 2016, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a ~~group residential~~ housing support payment to be made on the individual's behalf if the agency has approved the ~~individual's residence in a group residential~~ setting where the individual will receive housing ~~setting~~ support and the individual meets the requirements in paragraph (a) ~~or~~, (b), or (c).

(a) The individual is aged, blind, or is over 18 years of age and disabled 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 ~~group residential~~ 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), (5) to (9), and (14), 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 ~~group residential~~ 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.

EFFECTIVE DATE. Paragraph (c) is effective October 1, 2017.

Sec. 23. Minnesota Statutes 2016, section 256I.04, subdivision 2d, is amended to read:

Subd. 2d. **Conditions of payment; commissioner's right to suspend or terminate agreement.** (a) ~~Group residential~~ Housing ~~or supplementary services~~ support must be provided to the satisfaction of the commissioner, as determined at the sole discretion of the commissioner's authorized representative, and in accordance with all applicable federal, state, and local laws, ordinances, rules, and regulations, including business registration requirements of the Office of the Secretary of State. A provider shall not receive payment for room and board or supplementary services ~~or housing~~ found by the commissioner to be performed or provided in violation of federal, state, or local law, ordinance, rule, or regulation.

(b) The commissioner has the right to suspend or terminate the agreement immediately when the commissioner determines the health or welfare of the housing or service recipients is endangered, or when the commissioner has reasonable cause to believe that the provider has breached a material term of the agreement under subdivision 2b.

(c) Notwithstanding paragraph (b), if the commissioner learns of a curable material breach of the agreement by the provider, the commissioner shall provide the provider with a written notice of the breach and allow ten days to cure the breach. If the provider does not cure the breach within the time allowed, the provider shall be in default of the agreement and the commissioner may terminate the agreement immediately thereafter. If the provider has breached a material term of the agreement and cure is not possible, the commissioner may immediately terminate the agreement.

Sec. 24. Minnesota Statutes 2016, section 256I.04, subdivision 2g, is amended to read:

Subd. 2g. **Crisis shelters.** Secure crisis shelters for battered women and their children designated by the Minnesota Department of Corrections are not ~~group residences~~ eligible for housing support under this chapter.

Sec. 25. Minnesota Statutes 2016, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of ~~group residential~~ housing support beds.** (a) Agencies shall not enter into agreements for new ~~group residential~~ housing support beds with total rates in excess of the MSA equivalent rate except:

(1) for ~~group residential housing~~ establishments licensed under chapter 245D provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

(2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

(3) notwithstanding the provisions of subdivision 2a, for up to ~~190~~ 226 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the ~~group residential~~ housing support rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the ~~group residential~~ housing support supplementary service rate. A resident in a

demonstration project site who no longer participates in the demonstration program shall retain eligibility for a ~~group residential~~ housing support payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

(4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a ~~group residential~~ housing support contract with the county and has been licensed as a board and lodge facility with special services since 1980;

(5) for a ~~group residential~~ housing support provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

(6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a ~~group residential~~ housing support provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

(7) for a ~~group residential~~ housing support provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; and

(8) for a ~~group residential~~ facility authorized for recipients of housing support in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

(b) An agency may enter into a ~~group residential~~ housing support agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a ~~group residential~~ housing support agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from ~~group residential~~ housing support payment, or as a result of the downsizing of a ~~group residential housing~~ setting authorized for recipients of housing support. The transfer of available beds from one agency to another can only occur by the agreement of both agencies.

Sec. 26. Minnesota Statutes 2016, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board ~~provided by the group residence~~ if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under section 245.73. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the ~~GRH~~ housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the ~~GRH~~ housing support fund for beds under this section to other funding programs administered by the department after consultation with the county or counties in which the affected beds are located. The commissioner may also make cost-neutral transfers from the ~~GRH~~ housing support fund to county human service agencies for beds permanently removed from the ~~GRH~~ housing support census under a plan submitted by the county agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) Counties must not negotiate supplementary service rates with providers of ~~group residential~~ housing support that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

Sec. 27. Minnesota Statutes 2016, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for ~~group residential~~ housing support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

(a) An agency may increase the rates for ~~group residential housing settings~~ room and board to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) An agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total ~~group residential~~ housing support rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase ~~group residential housing~~ difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When ~~a group residential~~ housing ~~rate is used to pay~~ support pays for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences have received the prior approval of the county agency's social service staff. Prior approval is not required for emergency absences due to crisis, illness, or injury.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the ~~group residential housing~~ establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical

assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

Sec. 28. Minnesota Statutes 2016, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed ~~$700 per month~~ the maximum rate in subdivision 1a, including any legislatively authorized inflationary adjustments, for a ~~group residential~~ housing support provider that:

(1) is located in Hennepin County and has had a ~~group residential~~ housing support contract with the county since June 1996;

(2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a 26-bed facility; and

(3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

(b) Notwithstanding subdivisions 1a and 1c, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed ~~$700 per month~~ the maximum rate in subdivision 1a, including any legislatively authorized inflationary adjustments, of a ~~group residential~~ housing support provider that:

(1) is located in St. Louis County and has had a ~~group residential~~ housing support contract with the county since 2006;

(2) operates a 62-bed facility; and

(3) serves a chemically dependent adult male clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

(c) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for the ~~group residential~~ provider described under paragraphs (a) and (b), not to exceed an additional 115 beds.

Sec. 29. Minnesota Statutes 2016, section 256I.05, subdivision 1j, is amended to read:

Subd. 1j. **Supplementary rate for certain facilities; Crow Wing County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons operated by a ~~group residential~~ housing support provider that currently operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in January of 2006.

Sec. 30. Minnesota Statutes 2016, section 256I.05, subdivision 1m, is amended to read:

Subd. 1m. **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.** ~~(a)~~ Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency shall negotiate a supplemental service rate in addition to the rate specified in subdivision 1, not to exceed ~~$700 per month~~ the maximum rate in subdivision 1a or the existing monthly rate, whichever is higher, including any legislatively authorized inflationary adjustments, for a ~~group residential~~ housing support provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, which provide community support and serve the mental health needs of individuals who have chronically lived unsheltered, providing 24-hour-per-day supervision.

~~(b) An individual who has lived in one of the facilities under paragraph (a), who is being transitioned to independent living as part of the program plan continues to be eligible for group residential housing and the supplemental service rate negotiated with the county under paragraph (a).~~

Sec. 31. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1p. **Supplementary rate; St. Louis County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a housing support provider that:

(1) is located in St. Louis County and has had a housing support contract with the county since July 2016;

(2) operates a 35-bed facility;

(3) serves women who are chemically dependent, mentally ill, or both;

(4) provides 24-hour per day supervision;

(5) provides on-site support with skilled professionals, including a licensed practical nurse, registered nurses, peer specialists, and resident counselors; and

(6) provides independent living skills training and assistance with family reunification.

Sec. 32. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1q. **Supplemental rate; Olmsted County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Olmsted County that operates long-term residential facilities with a total of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day supervision and other support services.

Sec. 33. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1r. **Supplemental rate; Anoka County.** Notwithstanding the provisions in this section, a county agency shall negotiate a supplemental rate for 42 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a housing support provider that is located in Anoka County and provides emergency housing on the former Anoka Regional Treatment Center campus.

Sec. 34. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a cost-neutral transfer of funding from the housing support fund to county human service agencies for emergency shelter beds removed from the housing support census under a biennial plan submitted by the county and approved by the commissioner. The plan must describe: (1) anticipated and actual outcomes for persons experiencing homelessness in emergency shelters; (2) improved efficiencies in administration; (3) requirements for

individual eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review the county plan to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

(b) The funding under paragraph (a) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated annually, and the room and board portion of the allocation shall be adjusted according to the percentage change in the housing support room and board rate. The room and board portion of the allocation shall be determined at the time of transfer. The commissioner or county may return beds to the housing support fund with 180 days' notice, including financial reconciliation.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 35. Minnesota Statutes 2016, section 256I.06, subdivision 2, is amended to read:

Subd. 2. **Time of payment.** A county agency may make payments ~~to a group residence~~ in advance for an individual whose stay ~~in the group residence~~ is expected to last beyond the calendar month for which the payment is made. ~~Group residential~~ Housing support payments made by a county agency on behalf of an individual who is not expected to remain in the group residence beyond the month for which payment is made must be made subsequent to the individual's departure from the ~~group~~ residence.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 36. Minnesota Statutes 2016, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of ~~group residential~~ housing support payment.** (a) The amount of a ~~group residential housing~~ 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 ~~group residential housing charge~~ room and board rate for that same month. The ~~group residential~~ housing ~~charge~~ support payment is determined by multiplying the ~~group residential~~ 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, the amount of housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. Paragraph (c) is effective October 1, 2017.

Sec. 37. **[256I.09] COMMUNITY LIVING INFRASTRUCTURE.**

The commissioner shall award grants to agencies through an annual competitive process. Grants awarded under this section may be used for: (1) outreach to locate and engage people who are homeless or residing in segregated settings to screen for basic needs and assist with referral to community living resources; (2) building capacity to provide technical assistance and consultation on housing and related support service resources for persons with both disabilities and low income; or (3) streamlining the administration and monitoring activities related to housing support funds. Agencies may collaborate and submit a joint application for funding under this section.

Sec. 38. **GROUP RESIDENTIAL HOUSING; HOUSING SUPPORT SERVICES PLAN TO REVIEW SUPPLEMENTAL SERVICE RATES.**

(a) Since 1993, group residential housing supplementary service rates have been established in statute without a standard rate setting methodology, nor information about or an analysis of the actual cost the provider will sustain to provide the services. There are approximately 200 providers that receive more than 65 different monthly supplemental rates ranging from $44 to $5,000. Further, there are wide discrepancies between the services that are provided for the supplemental rate payment.

(b) The commissioner of human services shall develop: (1) a plan to review all supplemental rates over a sufficient time period, to be determined by the commissioner; (2) a process to modify the rate if it is either inadequate or excessive; and (3) a process to review supplemental rates prospectively, so the legislature has the foundation necessary in which to make a decision as to whether to approve the request for a supplemental rate. The information must be provided in a report to the senate and house of representatives committees with jurisdiction over group residential housing issues, along with proposed legislation to effectuate the plan and processes and a fiscal estimate by December 1, 2018.

Sec. 39. **REVISOR'S INSTRUCTION.**

In each section of Minnesota Statutes referred to in column A, the revisor of statutes shall change the phrase in column B to the phrase in column C. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text. The revisor shall make other changes in chapter titles; section, subdivision, part, and subpart headnotes; and in other terminology necessary as a result of the enactment of this section.

Column A	Column B	Column C
144A.071, subdivision 4d	group residential housing	housing support under chapter 256I
201.061, subdivision 3	group residential housing	setting authorized to provide housing support
244.052, subdivision 4c	group residential housing facility	licensed setting authorized to provide housing support under section 256I.04
245.466, subdivision 7	under group residential housing	by housing support under chapter 256I
245.466, subdivision 7	from group residential housing	from housing support
245.4661, subdivision 6	group residential housing	housing support under chapter 256I
245C.10, subdivision 11	group residential housing or supplementary services	housing support
256.01, subdivision 18	group residential housing	housing support under chapter 256I
256.017, subdivision 1	group residential housing	housing support
256.98, subdivision 8	group residential housing	housing support under chapter 256I
256B.49, subdivision 15	group residential housing	housing support under chapter 256I
256B.4914, subdivision 10	group residential housing rate 3 costs	housing support rate 3 costs under chapter 256I
256B.501, subdivision 4b	group residential housing	housing support
256B.77, subdivision 12	residential services covered under the group residential housing program	housing support services under chapter 256I
256D.44, subdivision 2	group residential housing facility	setting authorized to provide housing support
256G.01, subdivision 3	group residential housing	housing support under chapter 256I
256I.01	Group Residential Housing	Housing Support
256I.02	Group Residential Housing	Housing Support
256I.03, subdivision 2	"Group residential housing"	"Room and board"

256I.03, subdivision 2	Group residential housing	The room and board
256I.03, subdivision 3	"Group residential housing"	"Housing support"
256I.03, subdivision 6	group residential housing	room and board
256I.03, subdivisions 7 and 9	group residential housing	housing support
256I.04, subdivisions 1a, 1b, 1c, and 2	group residential housing	housing support
256I.04, subdivision 2a	provide group residential housing	provide housing support
256I.04, subdivision 2a	of group residential housing or supplementary services	of housing support
256I.04, subdivision 2a	complete group residential housing	complete housing support
256I.04, subdivision 2b	group residential housing or supplementary services	housing support
256I.04, subdivision 2b	provision of group residential housing	provision of housing support
256I.04, subdivision 2c	group residential housing or supplementary services	housing support
256I.04, subdivision 2e	group residential housing or supplementary services	housing support
256I.04, subdivision 4	group residential housing payment for room and board	room and board rate
256I.05, subdivision 1	living in group residential housing	receiving housing support
256I.05, subdivisions 1h, 1k, 1l, 7b, and 7c	group residential housing	housing support
256I.05, subdivision 2	group residential housing	room and board
256I.05, subdivision 3	group residential housing	room and board
256I.05, subdivision 6	reside in group residential housing	receive housing support
256I.06, subdivisions 1, 3, 4, and 6	group residential housing	housing support
256I.06, subdivision 7	group residential housing	the housing support
256I.08	group residential housing	housing support
256P.03, subdivision 1	group residential housing	housing support
256P.05, subdivision 1	group residential housing	housing support
256P.07, subdivision 1	group residential housing	housing support
256P.08, subdivision 1	group residential housing	housing support
290A.03, subdivision 8	accepts group residential housing	accepts housing support
290A.03, subdivision 8	the group residential housing program	the housing support program

ARTICLE 3

CONTINUING CARE

Section 1. Minnesota Statutes 2016, section 144.0724, subdivision 4, is amended to read:

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

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

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment;

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

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; and

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification.

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

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

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

Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 6, is amended to read:

Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within seven days of the time requirements listed in the Long-Term Care Facility Resident Assessment Instrument User's Manual is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, on the ARD for significant change in status assessments, or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission and acceptance of the resident's assessment.

(b) If loss of revenue due to penalties incurred by a facility for any period of 92 days are equal to or greater than ~~1.0~~ 0.1 percent of the total operating costs on the facility's most recent annual statistical and cost report, a facility may apply to the commissioner of human services for a reduction in the total penalty amount. The commissioner of human services, in consultation with the commissioner of health, may, at the sole discretion of the commissioner of human services, limit the penalty for residents covered by medical assistance to ~~15~~ ten days.

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

Sec. 3. Minnesota Statutes 2016, 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 of 2,000 days of swing bed use per year. 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) 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.

(d) 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.

(e) 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.

Sec. 4. Minnesota Statutes 2016, section 144A.071, subdivision 4d, as amended by Laws 2017, chapter 40, article 1, section 25, 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 ~~later of the first day of the month following~~ 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 ~~or the first day of the month following~~ and the complete ~~closure of a facility~~ 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 group residential housing;

(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.

EFFECTIVE DATE. This section is effective for consolidations occurring after July 1, 2017.

Sec. 5. Minnesota Statutes 2016, section 144A.74, is amended to read:

144A.74 MAXIMUM CHARGES.

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted average wage rate, plus a factor determined by the commissioner to incorporate payroll taxes as defined in ~~Minnesota Rules, part 9549.0020, subpart 33~~ section 256R.02, subdivision 37, for the applicable employee classification for the geographic group ~~to which the nursing home is assigned under Minnesota Rules, part 9549.0052~~ specified in section 256R.23,

subdivision 4. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Wages are defined as hourly rate of pay and shift differential, including weekend shift differential and overtime. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home. A nursing home that pays for the actual travel and housing costs for supplemental nursing services agency staff working at the facility and that pays these costs to the employee, the agency, or another vendor, is not violating the limitation on charges described in this section.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 6. Minnesota Statutes 2016, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, shall serve older adults as the designated Aging and Disability Resource Center under United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006 in partnership with the Disability Linkage Line under section 256.01, subdivision 24, and must be available during business hours through a statewide toll-free number and the Internet. The Minnesota Board on Aging shall consult with, and when appropriate work through, the area agencies on aging counties, and other entities that serve aging and disabled populations of all ages, to provide and maintain the telephone infrastructure and related support for the Aging and Disability Resource Center partners which agree by memorandum to access the infrastructure, including the designated providers of the Senior LinkAge Line and the Disability Linkage Line.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) using risk management and support planning protocols, provide long-term care options counseling under clause (13) to current residents of nursing homes deemed appropriate for discharge by the commissioner~~, former residents of nursing homes who~~

~~were discharged to community settings, and older adults who request service after consultation with the Senior LinkAge Line under clause (13). The Senior LinkAge Line shall also receive referrals from the residents or staff of nursing homes.~~ who meet a profile that demonstrates that the consumer is either at risk of readmission to a nursing home or hospital, or would benefit from long-term care options counseling to age in place. The Senior LinkAge Line shall identify and contact residents or patients deemed appropriate ~~for discharge~~ by developing targeting criteria and creating a profile in consultation with the commissioner ~~who~~. The commissioner shall provide designated Senior LinkAge Line contact centers with a list of current or former nursing home residents or people discharged from a hospital or for whom Medicare home care has ended, that meet the criteria as being appropriate for ~~discharge planning~~ long-term care options counseling through a referral via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment and, if appropriate, a referral to:

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

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

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

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

(c) Nursing homes shall provide contact information to the Senior LinkAge Line for residents identified in paragraph (b), clause (12), to provide long-term care options counseling pursuant to paragraph (b), clause (11). The contact information for residents shall include all information reasonably necessary to contact residents, including first and last names, permanent and temporary addresses, telephone numbers, and e-mail addresses.

(d) The Senior LinkAge Line shall determine when it is appropriate to refer a consumer who receives long-term care options counseling under paragraph (b), clause (12) or (13),

and who uses an unpaid caregiver to the self-directed caregiver service under subdivision 12.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 7. Minnesota Statutes 2016, section 256.975, is amended by adding a subdivision to read:

Subd. 12. **Self-directed caregiver grants.** Beginning on July 1, 2019, the Minnesota Board on Aging shall administer self-directed caregiver grants to support at risk family caregivers of older adults or others eligible under the Older Americans Act of 1965, United States Code, title 42, chapter 35, sections 3001 to 3058ff, to sustain family caregivers in the caregivers' roles so older adults can remain at home longer. The board shall give priority to consumers referred under section 256.975, subdivision 7, paragraph (d).

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 8. Minnesota Statutes 2016, 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, 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 interview with the person being assessed and the person's legal representative. 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.

(e) 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, regardless of whether the individual 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;

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

~~(f)~~ (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.

~~(g)~~ (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).

~~(h)~~ (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.

~~(i)~~ (k) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

~~(j)~~ (l) The effective eligibility start date for programs in paragraph ~~(i)~~(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 ~~(i)~~ (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.

Sec. 9. Minnesota Statutes 2016, 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 ~~256B.438~~ 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 ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous ~~June 30~~ December 31 shall be increased by the difference between any legislatively adopted home and community-based

provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ 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 ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 10. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the ~~greater of either the~~ statewide ~~or any of the geographic groups'~~ weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a). ~~Effective~~ On July 1 of ~~the state fiscal~~ each year ~~in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year~~, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) ~~Effective July 1, 2011,~~ The individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph ~~(d)~~ (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(h) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, individualized service rate limits for customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ 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 ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

EFFECTIVE DATE. This section prevails over any conflicting amendment regardless of the order of enactment.

Sec. 11. Minnesota Statutes 2016, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established

by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0051 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification

under Minnesota Rules, parts 9549.0051 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) Twenty-four-hour customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(i) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(j) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, individualized service rate limits for 24-hour customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ 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 ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 12. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months ~~and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital~~. There must be a determination that the client requires 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.

(b) 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 and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

(c) The lead agency shall conduct a change-in-condition reassessment before the annual reassessment in cases where a client's condition changed due to a major health event, an emerging need or risk, worsening health condition, or cases where the current services do not meet the client's needs. A change-in-condition reassessment may be initiated by the lead agency, or it may be requested by the client or requested on the client's behalf by another party, such as a provider of services. The lead agency shall complete a change-in-condition reassessment no later than 20 calendar days from the request. The lead agency shall conduct these assessments in a timely manner and expedite urgent requests. The lead agency shall evaluate urgent requests based on the client's needs and risk to the client if a reassessment is not completed.

Sec. 13. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 11. **Payment rates; application.** The payment methodologies in subdivisions 12 to 16 apply to elderly waiver and elderly waiver customized living under this section, alternative care under section 256B.0913, essential community supports under section 256B.0922, and community access for disability inclusion customized living, brain injury customized living, and elderly waiver foster care and residential care.

Sec. 14. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 12. **Payment rates; phase-in.** Effective January 1, 2019, all rates and rate components for services under subdivision 11 shall be the sum of ten percent of the rates calculated under subdivisions 13 to 16 and 90 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

Sec. 15. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 13. **Payment rates; establishment.** (a) When establishing the base wages according to subdivision 14, the commissioner shall use standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the edition of the Occupational Handbook published immediately prior to January 1, 2019, using Minnesota-specific wages taken from job descriptions.

(b) Beginning January 1, 2019, and every January 1 thereafter, the commissioner shall establish factors, component rates, and rates according to subdivisions 15 and 16, using base wages established according to paragraph (a) and subdivision 14.

Sec. 16. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 14. **Payment rates; base wage index.** (a) Base wages are calculated for customized living, foster care, and residential care component services as follows:

(1) the home management and support services base wage equals 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(2) the home care aide base wage equals 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health aides (SOC code 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014);

(3) the home health aide base wage equals 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed

vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and

(4) the medication setups by licensed practical nurse base wage equals ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 90 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

(b) Base wages are calculated for the following services as follows:

(1) the chore services base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping workers (SOC code 37-3011);

(2) the companion services base wage equals 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aides (SOC code 39-9021); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(3) the homemaker services and assistance with personal care base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(4) the homemaker services and cleaning base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(5) the homemaker services and home management base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(6) the in-home respite care services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061);

(7) the out-of-home respite care services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and

(8) the individual community living support base wage equals 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014).

(c) Base wages are calculated for the following values as follows:

(1) the registered nurse base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); and

(2) the social worker base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for medical and public health social workers (SOC code 21-1022).

(d) If any of the SOC codes and positions are no longer available, the commissioner shall, in consultation with stakeholders, select a new SOC code and position that is the closest match to the previously used SOC position.

Sec. 17. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 15. **Payment rates; factors.** The commissioner shall use the following factors:

(1) the payroll taxes and benefits factor is the sum of net payroll taxes and benefits divided by the sum of all salaries for all nursing facilities on the most recent and available cost report;

(2) the general and administrative factor is the sum of net general and administrative expenses minus administrative salaries divided by total operating expenses for all nursing facilities on the most recent and available cost report;

(3) the program plan support factor is 12.8 percent to cover the cost of direct service staff needed to provide support for the home and community-based service when not engaged in direct contact with clients.

(4) the registered nurse management and supervision factor equals 15 percent of the product of the position's base wage and the sum of the factors in clauses (1) to (3); and

(5) the social worker supervision factor equals 15 percent of the product of the position's base wage and the sum of the factors in clauses (1) to (3).

Sec. 18. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 16. **Payment rates; component rates.** (a) For the purposes of this subdivision, the "adjusted base wage" for a position equals the position's base wage plus:

(1) the position's base wage multiplied by the payroll taxes and benefits factor;

(2) the position's base wage multiplied by the general and administrative factor; and

(3) the position's base wage multiplied by the program plan support factor.

(b) For medication setups by licensed nurse, registered nurse, and social worker services, the component rate for each service equals the respective position's adjusted base wage.

(c) For home management and support services, home care aide, and home health aide services, the component rate for each service equals the respective position's adjusted base wage plus the registered nurse management and supervision factor.

(d) The home management and support services component rate shall be used for payment for socialization and transportation component rates under elderly waiver customized living.

(e) The 15-minute unit rates for chore services and companion services are calculated as follows:

(1) sum the adjusted base wage for the respective position and the social worker factor; and

(2) divide the result of clause (1) by four.

(f) The 15-minute unit rates for homemaker services and assistance with personal care, homemaker services and cleaning, and homemaker services and home management are calculated as follows:

(1) sum the adjusted base wage for the respective position and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(g) The 15-minute unit rate for in-home respite care services is calculated as follows:

(1) sum the adjusted base wage for in-home respite care services and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(h) The in-home respite care services daily rate equals the in-home respite care services 15-minute unit rate multiplied by 18.

(i) The 15-minute unit rate for out-of-home respite care is calculated as follows:

(1) sum the out-of-home respite care services adjusted base wage and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(j) The out-of-home respite care services daily rate equals the out-of-home respite care services 15-minute unit rate multiplied by 18.

(k) The individual community living support rate is calculated as follows:

(1) sum the adjusted base wage for the home care aide rate in subdivision 14, paragraph (a), clause (2), and the social worker factor; and

(2) divide the result of clause (1) by four.

(l) The home delivered meals rate equals $9.30. Beginning July 1, 2018, the commissioner shall increase the home delivered meals rate every July 1 by the percent increase in the nursing facility dietary per diem using the two most recent and available nursing facility cost reports.

(m) The adult day services rate is based on the home care aide rate in subdivision 14, paragraph (a), clause (2), plus the additional factors from subdivision 15, except that the general and administrative factor used shall be 20 percent. The nonregistered nurse portion of the rate shall be multiplied by 0.25, to reflect an assumed-ratio staffing of one caregiver to four clients, and divided by four to determine the 15-minute unit rate. The registered

nurse portion is divided by four to determine the 15-minute unit rate and $0.63 per 15-minute unit is added to cover the cost of meals.

(n) The adult day services bath 15-minute unit rate is the same as the calculation of the adult day services 15-minute unit rate without the adjustment for staffing ratio.

(o) If a bath is authorized for an adult day services client, at least two 15-minute units must be authorized to allow for adequate time to meet client needs. Adult day services may be authorized for up to 48 units, or 12 hours, per day based on client and family caregiver needs.

Sec. 19. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 17. **Evaluation of rate methodology.** The commissioner, in consultation with stakeholders, shall conduct a study to evaluate the following:

(1) base wages in subdivision 14, to determine if the standard occupational classification codes for each rate and component rate are an appropriate representation of staff who deliver the services; and

(2) factors in subdivision 15, and adjusted base wage calculation in subdivision 16, to determine if the factors and calculations appropriately address nonwage provider costs.

By January 1, 2019, the commissioner shall submit a report to the legislature on the changes to the rate methodology in this statute, based on the results of the evaluation. Where feasible, the report shall address the impact of the new rates on the workforce situation and client access to services. The report should include any changes to the rate calculations methods that the commissioner recommends.

Sec. 20. Minnesota Statutes 2016, section 256B.431, subdivision 10, is amended to read:

Subd. 10. **Property rate adjustments and construction projects.** A nursing facility completing a construction project that is eligible for a rate adjustment under section 256B.434, subdivision 4f, and that was not approved through the moratorium exception process in section 144A.073 must request from the commissioner a property-related payment rate adjustment. ~~If the request is made within 60 days after the construction project's completion date,~~ The effective date of the rate adjustment is the first of the month of January or July, whichever occurs first following both the construction project's completion date and submission of the provider's rate adjustment request. ~~If the request is made more than 60 days after the completion date, the rate adjustment is effective on the first of the month~~

~~following the request.~~ The commissioner shall provide a rate notice reflecting the allowable costs within 60 days after receiving all the necessary information to compute the rate adjustment. No sooner than the effective date of the rate adjustment for the construction project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective. Construction projects with completion dates within one year of the completion date associated with the property rate adjustment request and phased projects with project completion dates within three years of the last phase of the phased project must be aggregated for purposes of the minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section 144A.071, subdivision 2. "Construction project" and "project construction costs" have the meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

EFFECTIVE DATE. This section is effective for projects completed after January 1, 2018.

Sec. 21. Minnesota Statutes 2016, section 256B.431, subdivision 16, is amended to read:

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 ~~month in~~ date on which the addition or replacement is completed.

EFFECTIVE DATE. This section is effective for additions or replacements completed after January 1, 2018.

Sec. 22. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be

effective the first day of the month of January or July, whichever occurs first following the ~~month in~~ date on which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section ~~which~~ that has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the ~~month in~~ date on which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section~~,~~ ~~which~~ that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the ~~month in~~ date on which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section or section 256B.434, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section or section 256B.434, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

EFFECTIVE DATE. This section is effective for layaways occurring after July 1, 2017.

Sec. 23. Minnesota Statutes 2016, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, 2019, a nursing facility's ~~case mix~~ property payment ~~rates~~ rate for the second and subsequent years of a facility's contract under this section are the previous

rate year's ~~contract~~ property payment ~~rates~~ rate plus an inflation adjustment ~~and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001~~. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the ~~commissioner of management and budget's national economic consultant~~ Reports and Forecasts Division of the Department of Human Services, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. ~~For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property-related payment rate. For the rate years beginning on October 1, 2011, October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, January 1, 2016, and January 1, 2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.~~

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

Sec. 24. Minnesota Statutes 2016, section 256B.434, subdivision 4f, is amended to read:

Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a) Effective October 1, 2006, facilities reimbursed under this section may receive a property rate adjustment for construction projects exceeding the threshold in section 256B.431, subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are: (1) purchased within 24 months of the completion of the construction project; (2) purchased after the completion date of any prior construction project; and (3) are not purchased prior to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable construction projects under this subdivision and section 144A.073. Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible

for a property rate adjustment effective on the first day of the month following the completion date. Facilities completing projects after January 1, 2018, are eligible for a property rate adjustment effective on the first day of the month of January or July, whichever occurs immediately following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph (a). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

(g) For construction projects that were not approved under section 144A.073, allowable debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds.

For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section.

For a total replacement project as defined in section 256B.431, subdivision 17d, the value of previously existing capital debt shall be zero.

(h) In addition to the interest expense allowed from the application of paragraph (f), the amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and (3), will be added to interest expense.

(i) The equity portion of the construction project shall be computed as the allowable assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

(j) For projects that are not a total replacement of a nursing facility, the amount in paragraph (i) is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

(k) For projects that are a total replacement of a nursing facility, the amount in paragraph (i) becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431, subdivision 19, shall be removed from the facility's rates.

(l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060, subpart 10, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

(m) Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months of the completion of the future construction project.

(n) In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in subdivision 4.

(o) Construction projects are eligible for an equity incentive under section 256B.431, subdivision 16. When computing the equity incentive for a construction project under this subdivision, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under section 256B.431, subdivision 16, paragraph (c).

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 25. Minnesota Statutes 2016, section 256B.50, subdivision 1b, is amended to read:

Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be postmarked or received by the commissioner within 60 days of the publication date ~~the determination of the payment rate was mailed or personally received by a provider, whichever is earlier~~ printed on the rate notice. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the commissioner.

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

Sec. 26. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision to read:

Subd. 3a. **Therapeutic leave days.** Notwithstanding Minnesota Rules, part 9505.0415, subpart 7, a vacant bed in an intermediate care facility for persons with developmental disabilities shall be counted as a reserved bed when determining occupancy rates and eligibility for payment of a therapeutic leave day.

Sec. 27. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision to read:

Subd. 17. **ICF/DD rate increase effective July 1, 2017; Murray County.** Effective July 1, 2017, the daily rate for an intermediate care facility for persons with developmental

disabilities located in Murray County that is classified as a class B facility and licensed for 14 beds is $400. This increase is in addition to any other increase that is effective on July 1, 2017.

Sec. 28. Minnesota Statutes 2016, section 256R.02, subdivision 4, is amended to read:

Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, ~~and~~ permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 17, voice and data communication or transmission, office supplies, property and liability insurance and other forms of insurance ~~not designated to other areas~~ except insurance that is a fringe benefit under subdivision 22, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of directors fees, working capital interest expense, ~~and~~ bad debts, ~~and~~ bad debt collection fees, and costs incurred for travel and housing for persons employed by a supplemental nursing services agency as defined in section 144A.70, subdivision 6.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 29. Minnesota Statutes 2016, section 256R.02, subdivision 17, is amended to read:

Subd. 17. **Direct care costs.** "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training in resident care topics and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee schedule by the medical assistance program or any other payer, and technology related to the provision of nursing care to residents, such as electronic charting systems; costs of

materials used for resident care training, and training courses outside of the facility attended by direct care staff on resident care topics; and costs for nurse consultants, pharmacy consultants, and medical directors. Salaries and payroll taxes for nurse consultants who work out of a central office must be allocated proportionately by total resident days or by direct identification to the nursing facilities served by those consultants.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 30. Minnesota Statutes 2016, section 256R.02, subdivision 18, is amended to read:

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means premium expenses for group coverage ~~and reinsurance,~~; actual expenses incurred for self-insured plans, including reinsurance; and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for (1) all employees and (2) the spouse and dependents of those employees who ~~meet the definition of full-time employees under the federal Affordable Care Act, Public Law 111-148~~ are employed on average at least 30 hours per week.

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

Sec. 31. Minnesota Statutes 2016, 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, 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.

Sec. 32. Minnesota Statutes 2016, section 256R.02, subdivision 22, is amended to read:

Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, dental, workers' compensation, ~~and other employee insurances and~~ short- and long-term disability, long-term care insurance, accident insurance, supplemental insurance, legal assistance insurance, profit sharing, health insurance costs not covered under subdivision

18, including costs associated with part-time employee family members or retirees, and pension and retirement plan contributions, except for the Public Employees Retirement Association ~~and employer health insurance costs; profit sharing; and retirement plans for which the employer pays all or a portion of the~~ costs.

Sec. 33. Minnesota Statutes 2016, section 256R.02, subdivision 42, is amended to read:

Subd. 42. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing facility residents and the allocation of dietary credits. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

Sec. 34. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision to read:

Subd. 42a. **Real estate taxes.** "Real estate taxes" means the real estate tax liability shown on the annual property tax statement of the nursing facility for the reporting period. The term does not include personnel costs or fees for late payment.

Sec. 35. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision to read:

Subd. 48a. **Special assessments.** "Special assessments" means the actual special assessments and related interest paid during the reporting period. The term does not include personnel costs or fees for late payment.

Sec. 36. Minnesota Statutes 2016, section 256R.02, subdivision 52, is amended to read:

Subd. 52. **Therapy costs.** "Therapy costs" means any costs related to ~~medical assistance~~ therapy services provided to residents that are not ~~billed~~ separately billable from the daily operating rate.

Sec. 37. Minnesota Statutes 2016, section 256R.06, subdivision 5, is amended to read:

Subd. 5. **Notice to residents.** (a) No increase in nursing facility rates for private paying residents shall be effective unless the nursing facility notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect. The notice must include the amount of the rate increase, the new payment rate, and the date the rate increase takes effect.

A nursing facility may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to reflect a change in the case mix

classification of the resident. The nursing facility shall notify private pay residents of any rate increase related to a change in case mix classifications in a timely manner after confirmation of the case mix classification change is received from the Department of Health.

If the state fails to set rates as required by section 256R.09, subdivision 1, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

(b) If the state does not set rates by the date required in section 256R.09, subdivision 1, or otherwise provides nursing facilities with retroactive notification of the amount of a rate increase, nursing facilities shall meet the requirement for advance notice by informing the resident or person responsible for payments, on or before the effective date of the increase, that a rate increase will be effective on that date. The requirements of paragraph (a) do not apply to situations described in this paragraph.

If the exact amount has not yet been determined, the nursing facility may raise the rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective.

Sec. 38. Minnesota Statutes 2016, section 256R.07, is amended by adding a subdivision to read:

Subd. 6. **Electronic signature.** For documentation requiring a signature under this chapter or section 256B.431 or 256B.434, use of an electronic signature as defined under section 325L.02, paragraph (h), is allowed.

Sec. 39. Minnesota Statutes 2016, section 256R.10, is amended by adding a subdivision to read:

Subd. 7. **Not specified allowed costs.** When the cost category for allowed cost items or services is not specified in this chapter or the provider reimbursement manual, the commissioner, in consultation with stakeholders, shall determine the cost category for the allowed cost item or service.

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

Sec. 40. **[256R.18] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

Beginning January 1, 2019, the commissioner shall provide to the house of representatives and senate committees with jurisdiction over nursing facility payment rates a biennial report on the effectiveness of the reimbursement system in improving quality, restraining costs, and any other features of the system as determined by the commissioner.

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

Sec. 41. Minnesota Statutes 2016, section 256R.37, is amended to read:

256R.37 SCHOLARSHIPS.

(a) For the 27-month period beginning October 1, 2015, through December 31, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least ten hours per week at the facility except the administrator, and to reimburse student loan expenses for newly hired ~~and recently graduated~~ registered nurses and licensed practical nurses, and training expenses for nursing assistants as specified in section 144A.611, subdivisions 2 and 4, who are newly hired ~~and have graduated within the last 12 months~~; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) All facilities may annually request a rate adjustment under this section by submitting information to the commissioner on a schedule and in a form supplied by the commissioner. The commissioner shall allow a scholarship payment rate equal to the reported and allowable costs divided by resident days.

(c) In calculating the per diem under paragraph (b), the commissioner shall allow costs related to tuition, direct educational expenses, and reasonable costs as defined by the commissioner for child care costs and transportation expenses related to direct educational expenses.

(d) The rate increase under this section is an optional rate add-on that the facility must request from the commissioner in a manner prescribed by the commissioner. The rate increase must be used for scholarships as specified in this section.

(e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities that close beds during a rate year may request to have their scholarship adjustment under paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect the reduction in resident days compared to the cost report year.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 42. Minnesota Statutes 2016, section 256R.40, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility or the date that beds from a partial closure are delicensed and decertified.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Sec. 43. Minnesota Statutes 2016, section 256R.40, subdivision 5, is amended to read:

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month of January or July, whichever occurs immediately following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

EFFECTIVE DATE. This section is effective for closures occurring after July 1, 2017.

Sec. 44. Minnesota Statutes 2016, section 256R.41, is amended to read:

256R.41 SINGLE-BED ROOM INCENTIVE.

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility ~~during a calendar quarter~~ that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on either the first day of the ~~second~~ month of January or July, whichever occurs first following ~~that calendar quarter~~ the date of the bed delicensure.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has

discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

EFFECTIVE DATE. This section is effective for closures occurring after July 1, 2017.

Sec. 45. Minnesota Statutes 2016, section 256R.47, is amended to read:

256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner

of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility is for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, to December 31, ~~2017~~ 2019.

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

Sec. 46. Minnesota Statutes 2016, section 256R.49, subdivision 1, is amended to read:

Subdivision 1. **Rate adjustments for compensation-related costs.** (a) ~~Operating payment rates of all nursing facilities that are reimbursed under this chapter shall be increased effective for rate years beginning on and after October 1, 2014, to address changes in compensation costs for nursing facility employees paid less than $14 per hour in accordance with this section.~~ Rate increases provided under this section before October 1, 2016, expire effective January 1, 2018, and rate increases provided on or after October 1, 2016, expire effective January 1, 2019.

(b) Nursing facilities that receive approval of the applications in subdivision 2 must receive rate adjustments according to subdivision 4. The rate adjustments must be used to pay compensation costs for nursing facility employees paid less than $14 per hour.

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

Sec. 47. **DIRECTION TO THE COMMISSIONER; ADULT DAY SERVICES STAFFING RATIOS; ELDERLY WAIVER.**

The commissioner of human services shall:

(1) study existing adult day services models, including resident acuity, staffing and support levels, and quality assurance;

(2) project demand for adult day services into the future; and

(3) report to the legislature by January 1, 2019.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 48. **ALZHEIMER'S DISEASE WORKING GROUP.**

Subdivision 1. **Members.** (a) The Minnesota Board on Aging must appoint 16 members to an Alzheimer's disease working group, as follows:

(1) a caregiver of a person who has been diagnosed with Alzheimer's disease;

(2) a person who has been diagnosed with Alzheimer's disease;

(3) two representatives from the nursing facility or senior housing profession;

(4) a representative of the home care or adult day services profession;

(5) two geriatricians, one of whom serves a diverse or underserved community;

(6) a psychologist who specializes in dementia care;

(7) an Alzheimer's researcher;

(8) a representative of the Alzheimer's Association;

(9) two members from community-based organizations serving one or more diverse or underserved communities;

(10) the commissioner of human services or a designee;

(11) the commissioner of health or a designee;

(12) the ombudsman for long-term care or a designee; and

(13) one member of the Minnesota Board on Aging, selected by the board.

(b) The executive director of the Minnesota Board on Aging serves on the working group as a nonvoting member.

(c) The appointing authorities under this subdivision must complete their appointments no later than December 15, 2017.

(d) To the extent practicable, the membership of the working group must reflect the diversity in Minnesota, and must include representatives from rural and metropolitan areas and representatives of different ethnicities, races, genders, ages, cultural groups, and abilities.

Subd. 2. **Duties; recommendations.** The Alzheimer's disease working group must review and revise the 2011 report, Preparing Minnesota for Alzheimer's: the Budgetary,

Social and Personal Impacts. The working group shall consider and make recommendations and findings on the following issues as related to Alzheimer's disease or other dementias:

(1) analysis and assessment of public health and health care data to accurately determine trends and disparities in cognitive decline;

(2) public awareness, knowledge, and attitudes, including knowledge gaps, stigma, availability of information, and supportive community environments;

(3) risk reduction, including health education and health promotion on risk factors, safety, and potentially avoidable hospitalizations;

(4) diagnosis and treatment, including early detection, access to diagnosis, quality of dementia care, and cost of treatment;

(5) professional education and training, including geriatric education for licensed health care professionals and dementia-specific training for direct care workers, first responders, and other professionals in communities;

(6) residential services, including cost to families as well as regulation and licensing gaps; and

(7) cultural competence and responsiveness to reduce health disparities and improve access to high-quality dementia care.

Subd. 3. **Meetings.** The Board on Aging must convene the first meeting of the working group no later than January 15, 2018. Before the first meeting, the Board on Aging must designate one member to serve as chair. Meetings of the working group must be open to the public, and to the extent practicable, technological means, such as Web casts, shall be used to reach the greatest number of people throughout the state. The working group may not meet more than five times.

Subd. 4. **Compensation.** Members of the working group serve without compensation, but may be reimbursed for allowed actual and necessary expenses incurred in the performance of the member's duties for the working group in the same manner and amount as authorized by the commissioner's plan adopted under Minnesota Statutes, section 43A.18, subdivision 2.

Subd. 5. **Administrative support.** The Minnesota Board on Aging shall provide administrative support and arrange meeting space for the working group.

Subd. 6. **Report.** The Board on Aging must submit a report providing the findings and recommendations of the working group, including any draft legislation necessary to

implement the recommendations, to the governor and chairs and ranking minority members of the legislative committees with jurisdiction over health care by January 15, 2019.

Subd. 7. **Expiration.** The working group expires June 30, 2019, or the day after the working group submits the report required in subdivision 6, whichever is earlier.

Sec. 49. **ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM.**

Subdivision 1. **Documentation; establishment.** The commissioner of human services shall establish implementation requirements and standards for an electronic service delivery documentation system 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" 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 system" means a system that provides electronic service delivery documentation 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.

Subd. 3. **Requirements.** (a) In developing implementation requirements for an electronic service delivery documentation system, 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;

(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 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 requirements on program integrity.

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.

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

Sec. 50. **DIRECTION TO COMMISSIONER; ICF/DD PAYMENT RATE STUDY.**

Within available appropriations, the commissioner of human services shall study the intermediate care facility for persons with developmental disabilities payment rates under Minnesota Statutes, sections 256B.5011 to 256B.5013, and make recommendations on the rate structure to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by January 15, 2018.

Sec. 51. **REVISOR'S INSTRUCTION.**

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 2018 legislative session to recodify laws governing the elderly waiver program in Minnesota Statutes, chapter 256B.

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

ARTICLE 4

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision to read:

Subd. 2a. **Audits of Department of Human Services.** (a) To ensure continuous legislative oversight and accountability, the legislative auditor shall give high priority to auditing the programs, services, and benefits administered by the Department of Human Services. The audits shall determine whether the department offered programs and provided services and benefits only to eligible persons and organizations, and complied with applicable legal requirements.

(b) The legislative auditor shall, based on an assessment of risk and using professional standards to provide a statistically significant sample, no less than three times each year, test a representative sample of persons enrolled in a medical assistance program or MinnesotaCare to determine whether they are eligible to receive benefits under those programs. The legislative auditor shall report the results to the commissioner of human services and recommend corrective actions. The commissioner shall provide a response to the legislative auditor within 20 business days, including corrective actions to be taken to address any problems identified by the legislative auditor and anticipated completion dates.

The legislative auditor shall monitor the commissioner's implementation of corrective actions and periodically report the results to the Legislative Audit Commission and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The legislative auditor's reports to the commission and the chairs and ranking minority members must include recommendations for any legislative actions needed to ensure that medical assistance and MinnesotaCare benefits are provided only to eligible persons.

Sec. 2. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision to read:

Subd. 2b. **Audits of managed care organizations.** (a) The legislative auditor shall audit each managed care organization that contracts with the commissioner of human services to provide health care services under sections 256B.69, 256B.692, and 256L.12. The legislative auditor shall design the audits to determine if a managed care organization used the public money in compliance with federal and state laws, rules, and in accordance with provisions in the managed care organization's contract with the commissioner of human services. The legislative auditor shall determine the schedule and scope of the audit work and may contract with vendors to assist with the audits. The managed care organization must cooperate with the legislative auditor and must provide the legislative auditor with all data, documents, and other information, regardless of classification, that the legislative auditor requests to conduct an audit. The legislative auditor shall periodically report audit results and recommendations to the Legislative Audit Commission and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

(b) For purposes of this subdivision, a "managed care organization" means a demonstration provider as defined under section 256B.69, subdivision 2.

Sec. 3. Minnesota Statutes 2016, section 62U.02, is amended to read:

62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures for use by health plan companies as specified in subdivision 5. As part of the standardized set of measures, the commissioner shall establish statewide measures by which to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. ~~Quality measures must be based on medical evidence and be developed through a process in which providers participate.~~ The statewide measures shall be used for the quality incentive payment

system developed in subdivision 2 and the quality transparency requirements in subdivision 3. The statewide measures must:

(1) for purposes of assessing the quality of care provided at physician clinics, including clinics certified as health care homes under section 256B.0751, be selected from the available measures as defined in Code of Federal Regulations, title 42, part 414 or 495, as amended, unless the stakeholders identified under paragraph (b) determine that a particular diagnosis, condition, service, or procedure is not reflected in any of the available measures in a way that meets identified needs;

(2) be based on medical evidence;

(3) be developed through a process in which providers participate and consumer and community input and perspectives are obtained;

~~(1)~~ (4) include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

~~(2)~~ (5) seek to avoid increasing the administrative burden on health care providers; and

~~(3) be initially based on existing quality indicators for physician and hospital services, which are measured and reported publicly by quality measurement organizations, including, but not limited to, Minnesota Community Measurement and specialty societies;~~

~~(4)~~ (6) place a priority on measures of health care outcomes, rather than process measures, wherever possible~~; and~~

~~(5) incorporate measures for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and other measures as determined by the commissioner~~.

The measures may also include measures of care infrastructure and patient satisfaction.

(b) By June 30, 2018, the commissioner shall develop a measurement framework that identifies the most important elements for assessing the quality of care, articulates statewide quality improvement goals, ensures clinical relevance, fosters alignment with other measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the commissioner shall use the framework to update the statewide measures used to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. No more than six statewide measures shall be required for single-specialty physician practices and no more than ten statewide measures shall be required for multispecialty physician practices. Measures in addition to the six statewide measures for single-specialty practices and the ten statewide

measures for multispecialty practices may be included for a physician practice if derived from administrative claims data. Care infrastructure measures collected according to section 62J.495 shall not be counted toward the maximum number of measures specified in this paragraph. The commissioner shall develop the framework in consultation with stakeholders that include consumer, community, and advocacy organizations representing diverse communities and patients; health plan companies; health care providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health care purchasers; community health boards; and quality improvement and measurement organizations. The commissioner, in consultation with stakeholders, shall review the framework at least once every three years. The commissioner shall also submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by September 30, 2018, summarizing the development of the measurement framework and making recommendations on the type and appropriate maximum number of measures in the statewide measures set for implementation on January 1, 2020.

~~(b)~~ (c) Effective July 1, 2016, the commissioner shall stratify quality measures by race, ethnicity, preferred language, and country of origin beginning with five measures, and stratifying additional measures to the extent resources are available. On or after January 1, 2018, the commissioner may require measures to be stratified by other sociodemographic factors or composite indices of multiple factors that according to reliable data are correlated with health disparities and have an impact on performance on quality or cost indicators. New methods of stratifying data under this paragraph must be tested and evaluated through pilot projects prior to adding them to the statewide system. In determining whether to add additional sociodemographic factors and developing the methodology to be used, the commissioner shall consider the reporting burden on providers and determine whether there are alternative sources of data that could be used. The commissioner shall ensure that categories and data collection methods are developed in consultation with those communities impacted by health disparities using culturally appropriate community engagement principles and methods. The commissioner shall implement this paragraph in coordination with the contracting entity retained under subdivision 4, in order to build upon the data stratification methodology that has been developed and tested by the entity. Nothing in this paragraph expands or changes the commissioner's authority to collect, analyze, or report health care data. Any data collected to implement this paragraph must be data that is available or is authorized to be collected under other laws. Nothing in this paragraph grants authority to the commissioner to collect or analyze patient-level or patient-specific data of the patient characteristics identified under this paragraph.

~~(c)~~ (d) The statewide measures shall be reviewed at least annually by the commissioner.

Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall develop a system of quality incentive payments under which providers are eligible for quality-based payments that are in addition to existing payment levels, based upon a comparison of provider performance against specified targets, and improvement over time. The targets must be based upon and consistent with the quality measures established under subdivision 1.

(b) To the extent possible, the payment system must adjust for variations in patient population in order to reduce incentives to health care providers to avoid high-risk patients or populations, including those with risk factors related to race, ethnicity, language, country of origin, and sociodemographic factors.

(c) The requirements of section 62Q.101 do not apply under this incentive payment system.

Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue ~~annual~~ periodic public reports on trends in provider quality ~~beginning July 1, 2010~~ at the statewide, regional, or clinic levels.

(b) Effective July 1, 2017, the risk adjustment system established under this subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph ~~(b)~~ (c), that are correlated with health disparities and have an impact on performance on cost and quality measures. The risk adjustment method may consist of reporting based on an actual-to-expected comparison that reflects the characteristics of the patient population served by the clinic or hospital. The commissioner shall implement this paragraph in coordination with any contracting entity retained under subdivision 4.

(c) ~~By January 1, 2010,~~ Physician clinics and hospitals shall submit standardized ~~electronic~~ information ~~on the outcomes and processes associated with patient care~~ for the identified statewide measures to the commissioner or the commissioner's designee in the formats specified by the commissioner, which must include alternative formats for clinics or hospitals experiencing technological or economic barriers to submission in standardized electronic form. ~~In addition to measures of care processes and outcomes, the report may include other measures designated by the commissioner, including, but not limited to, care infrastructure and patient satisfaction. The commissioner shall ensure that any quality data reporting requirements established under this subdivision are not duplicative of publicly reported, communitywide quality reporting activities currently under way in Minnesota.~~

The commissioner shall ensure that any quality data reporting requirements for physician clinics are aligned with the specifications and timelines for the selected measures as defined in subdivision 1, paragraph (a), clause (1). The commissioner may develop additional data on race, ethnicity, preferred language, country of origin, or other sociodemographic factors as identified under subdivision 1, paragraph (c), and as required for stratification or risk adjustment. None of the statewide measures selected shall require providers to use an external vendor to administer or collect data. ~~Nothing in this subdivision is intended to replace or duplicate current privately supported activities related to quality measurement and reporting in Minnesota.~~

Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium of private entities to complete the tasks in subdivisions 1 to 3. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, including providers serving high concentrations of patients and communities impacted by health disparities; health plan companies; consumers, including consumers representing groups who experience health disparities; employers or other health care purchasers; and state government. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 5. **Implementation.** ~~(a) By January 1, 2010,~~ Health plan companies shall use the standardized ~~quality~~ set of measures established under this section and shall not require providers to use and report health plan company-specific quality and outcome measures.

~~(b) By July 1, 2010, the commissioner of management and budget shall implement this incentive payment system for all participants in the state employee group insurance program.~~

Sec. 4. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 18f. **Asset verification system.** The commissioner shall implement the Asset Verification System (AVS) according to Public Law 110-252, title VII, section 7001(d), to verify assets for an individual applying for or renewing health care benefits under section 256B.055, subdivision 7.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 5. Minnesota Statutes 2016, section 256.9685, subdivision 1, is amended to read:

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

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

Sec. 6. Minnesota Statutes 2016, section 256.9685, subdivision 1a, is amended to read:

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

Sec. 7. Minnesota Statutes 2016, section 256.9686, subdivision 8, is amended to read:

Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31. Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June 30.

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

Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

(b) Except as authorized under this section, for fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 9. Minnesota Statutes 2016, 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 ~~that occurs~~ 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.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 3a, is amended to read:

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

reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. Services that have rates established under subdivision ~~11 or~~ 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates 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 ~~the~~ October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 11. Minnesota Statutes 2016, section 256.969, subdivision 8, is amended to read:

Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day outlier thresholds for each diagnostic category established under subdivision 2 at two standard deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold shall be in addition to the operating and property payment rates per admission established under subdivisions 2 and 2b. Payment for outliers shall be at 70 percent of the allowable operating cost, after adjustment by the case mix index, hospital cost index, relative values and the disproportionate population adjustment. The outlier threshold for neonatal and burn diagnostic categories shall be established at one standard deviation beyond the mean length of stay, and payment shall be at 90 percent of allowable operating cost calculated in the same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier payment that is at a minimum of 60 percent and a maximum of 80 percent if the commissioner is notified in writing of the request by October 1 of the year preceding the rate year. The chosen percentage applies to all diagnostic categories except burns and neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall be added back to the base year operating payment rate per admission.

(b) Effective for admissions and transfers occurring on and after November 1, 2014, the commissioner shall establish payment rates for outlier payments that are based on Medicare methodologies.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 12. Minnesota Statutes 2016, section 256.969, subdivision 8c, is amended to read:

Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1, 2014, payments for hospital residents shall be made as follows:

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

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

(b) For discharges occurring on or after July 1, 2017, payment for hospital residents shall be equal to the payments under subdivision 8, paragraph (b).

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 13. Minnesota Statutes 2016, 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 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 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 ~~nonchildren's~~ non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 14. Minnesota Statutes 2016, section 256.969, subdivision 12, is amended to read:

Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) Units of hospitals that are recognized as rehabilitation distinct parts by the Medicare program shall have separate provider numbers under the medical assistance program for rate establishment and billing purposes only. These units shall also have operating payment rates and the disproportionate population adjustment, if allowed by federal law, established separately from other inpatient hospital services.

(b) The commissioner shall establish separate relative values under subdivision 2 for rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for discharges occurring on and after November 1, 2014, the commissioner, to the extent possible, shall replicate the existing payment rate methodology under the new diagnostic classification system. The result must be budget neutral, ensuring that the total aggregate payments under the new system are equal to the total aggregate payments made for the same number and types of services in the base year, calendar year 2012.

(c) For individual hospitals that did not have separate medical assistance rehabilitation provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the information needed to separate rehabilitation distinct part cost and claims data from other inpatient service data.

(d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals shall be established under subdivision 2b, paragraph (a), clause (4).

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 15. Minnesota Statutes 2016, section 256.9695, subdivision 1, is amended to read:

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and

underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge ratios, and policy adjusters shall not be ~~recalculated~~ changed. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the Office of Administrative Hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

~~(a)~~ To appeal a payment rate or payment determination or a determination made from base year information, the hospital shall file a written appeal request to the commissioner within 60 days of the date the preliminary payment rate determination was mailed. The appeal request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or rule upon which the hospital relies for each disputed item; and (iii) the name and address of the person to contact regarding the appeal. Facts to be considered in any appeal of base year information are limited to those in existence ~~at the time the payment rates of the first rate year were established from the base year information. In the case of Medicare settled appeals, the 60-day appeal period shall begin on the mailing date of the notice by the Medicare program or the date the medical assistance payment rate determination notice is mailed, whichever is later~~ 12 months after the last day of the calendar year that is the base year for the payment rates in dispute.

~~(b) To appeal a payment rate or payment change that results from a difference in case mix between the base year and a rate year, the procedures and requirements of paragraph (a) apply. However, the appeal must be filed with the commissioner within 120 days after the end of a rate year. A case mix appeal must apply to the cost of services to all medical assistance patients that received inpatient services from the hospital during the rate year appealed. For case mix appeals filed after January 1, 1997, the difference in case mix and the corresponding payment adjustment must exceed a threshold of five percent.~~

Sec. 16. Minnesota Statutes 2016, section 256B.04, subdivision 12, is amended to read:

Subd. 12. **Limitation on services.** (a) Place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service. The state agency shall promulgate rules establishing maximum reimbursement rates for emergency and nonemergency transportation.

The rules shall provide:

(1) an opportunity for all recognized transportation providers to be reimbursed for nonemergency transportation consistent with the maximum rates established by the agency; and

(2) reimbursement of public and private nonprofit providers serving the disabled population generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter~~;~~ ~~and~~.

~~(3) reimbursement for each additional passenger carried on a single trip at a substantially lower rate than the first passenger carried on that trip.~~

(b) The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs.

(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner.

Sec. 17. Minnesota Statutes 2016, section 256B.04, subdivision 24, is amended to read:

Subd. 24. **Medicaid waiver requests and state plan amendments.** The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance at least 30 days before submitting a new Medicaid waiver request to the federal government. Prior to submitting any Medicaid waiver request or Medicaid state plan amendment to the federal government for approval, the commissioner shall publish the text of the waiver request or state plan amendment, and a summary of and explanation of the need for the request, on the agency's Web site and provide a 30-day public comment period. The commissioner shall notify the public of the availability of this information through the agency's electronic subscription service. The commissioner shall consider public comments when preparing the final waiver request or state plan amendment that is to be submitted to the federal government for approval. The commissioner shall also

publish on the agency's Web site notice of any federal decision related to the state request for approval, within 30 days of the decision. This notice must describe any modifications to the state request that have been agreed to by the commissioner as a condition of receiving federal approval.

Sec. 18. Minnesota Statutes 2016, section 256B.056, subdivision 3b, is amended to read:

Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) ~~Except as provided in paragraphs (c) and (d),~~ Trusts established after August 10, 1993, are treated according to ~~section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law 103-66~~ United States Code, title 42, section 1396p(d).

(c) For purposes of paragraph (d), a pooled trust means a trust established under United States Code, title 42, section 1396p(d)(4)(C).

(d) A beneficiary's interest in a pooled trust is considered an available asset unless the trust provides that upon the death of the beneficiary or termination of the trust during the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the beneficiary's trust account after a deduction for reasonable administrative fees and expenses, and an additional remainder amount. The retained remainder amount of the subaccount must not exceed ten percent of the account value at the time of the beneficiary's death or termination of the trust, and must only be used for the benefit of disabled individuals who have a beneficiary interest in the pooled trust.

(e) Trusts may be established on or after December 12, 2016, by a person who has been determined to be disabled, according to United States Code, title 42, section 1396p(d)(4)(A), as amended by section 5007 of the 21st Century Cures Act, Public Law 114-255.

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

Sec. 19. Minnesota Statutes 2016, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. 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 value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 20. Minnesota Statutes 2016, 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 ~~80~~ 81 percent of the federal poverty guidelines.

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

Sec. 21. Minnesota Statutes 2016, section 256B.0561, subdivision 2, is amended to read:

Subd. 2. **Periodic data matching.** (a) Beginning ~~March 1, 2016~~ April 1, 2018, the commissioner shall conduct periodic data matching to identify recipients who, based on available electronic data, may not meet eligibility criteria for the public health care program in which the recipient is enrolled. The commissioner shall conduct data matching for medical assistance or MinnesotaCare recipients at least once during a recipient's 12-month period of eligibility.

(b) If data matching indicates a recipient may no longer qualify for medical assistance or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no more than 30 days to confirm the information obtained through the periodic data matching or provide a reasonable explanation for the discrepancy to the state or county agency directly responsible for the recipient's case. If a recipient does not respond within the advance notice period or does not respond with information that demonstrates eligibility or provides a reasonable explanation for the discrepancy within the 30-day time period, the commissioner shall terminate the recipient's eligibility in the manner provided for by the laws and regulations governing the health care program for which the recipient has been identified as being ineligible.

(c) The commissioner shall not terminate eligibility for a recipient who is cooperating with the requirements of paragraph (b) and needs additional time to provide information in response to the notification.

(d) Any termination of eligibility for benefits under this section may be appealed as provided for in sections 256.045 to 256.0451, and the laws governing the health care programs for which eligibility is terminated.

Sec. 22. Minnesota Statutes 2016, section 256B.0561, subdivision 4, is amended to read:

Subd. 4. **Report.** By September 1, ~~2017~~ 2018, and each September 1 thereafter, the commissioner shall submit a report to the chairs and ranking minority members of the house and senate committees with jurisdiction over human services finance that includes the number of cases affected by periodic data matching under this section, the number of recipients identified as possibly ineligible as a result of a periodic data match, and the number of recipients whose eligibility was terminated as a result of a periodic data match. The report must also specify, for recipients whose eligibility was terminated, how many cases were closed due to failure to cooperate.

Sec. 23. Minnesota Statutes 2016, section 256B.057, subdivision 9, as amended by Laws 2017, chapter 59, section 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) meets the asset limits in paragraph (d); and

(3) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, advanced practice registered nurse, or physician assistant; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums 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.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. ~~Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met~~ "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

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

Sec. 24. Minnesota Statutes 2016, section 256B.059, subdivision 6, as amended by Laws 2017, chapter 40, article 1, section 66, is amended to read:

Subd. 6. **Temporary application.** (a) During the period in which rules against spousal impoverishment are temporarily applied according to section 2404 of the Patient Protection Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, this section applies to an institutionalized spouse:

(1) applying for home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 on or after June 1, 2016;

(2) enrolled in home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 before June 1, 2016, based on an application submitted on or after January 1, 2014; or

(3) applying for services under section 256B.85 upon the effective date of that section.

(b) During the applicable period of paragraph (a), the definition of "institutionalized spouse" in subdivision 1, paragraph (e), also includes an institutionalized spouse referenced in paragraph (a).

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

Sec. 25. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face ~~and~~ contact, telephone ~~contacts~~ contact, and interactive video contact according to section 256B.0924, subdivision 4a, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

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. 26. Minnesota Statutes 2016, section 256B.0625, subdivision 1, is amended to read:

Subdivision 1. **Inpatient hospital services.** (a) Medical assistance covers inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries requiring a second opinion. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion prior to reimbursement,

and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal.

(b) When determining medical necessity for inpatient hospital services, the medical review agent shall follow industry standard medical necessity criteria in determining the following:

(1) whether a recipient's admission is medically necessary;

(2) whether the inpatient hospital services provided to the recipient were medically necessary;

(3) whether the recipient's continued stay was or will be medically necessary; and

(4) whether all medically necessary inpatient hospital services were provided to the recipient.

The medical review agent will determine medical necessity of inpatient hospital services, including inpatient psychiatric treatment, based on a review of the patient's medical condition and records, in conjunction with industry standard evidence-based criteria to ensure consistent and optimal application of medical appropriateness criteria.

Sec. 27. Minnesota Statutes 2016, 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. 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" ~~is defined~~ 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; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

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

Sec. 28. Minnesota Statutes 2016, section 256B.0625, subdivision 7, is amended to read:

Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in a recipient's home. Recipients who are authorized to receive home care nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use home care nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover home care nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, ~~except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or~~ unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home care nursing services or forgoes the facility per diem for the leave days that home care nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to sections 256B.0651 and 256B.0654 . All home care nursing services must be provided according to the limits established under sections 256B.0651, 256B.0653, and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family foster care provider of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

Sec. 29. Minnesota Statutes 2016, 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, ~~common carrier~~ 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 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~~, which may not be implemented without a new rate structure,~~ 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).

Sec. 30. Minnesota Statutes 2016, section 256B.0625, subdivision 17b, is amended to read:

Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain odometer and other records sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision shall be recovered by the department.

(b) A nonemergency medical transportation provider must compile transportation records that meet the following requirements:

(1) the record must be in English and must be legible according to the standard of a reasonable person;

(2) the recipient's name must be on each page of the record; and

(3) each entry in the record must document:

(i) the date on which the entry is made;

(ii) the date or dates the service is provided;

(iii) the printed last name, first name, and middle initial of the driver;

(iv) the signature of the driver attesting to the following: "I certify that I have accurately reported in this record the trip miles I actually drove and the dates and times I actually drove

them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings.";

(v) the signature of the recipient or authorized party attesting to the following: "I certify that I received the reported transportation service.", or the signature of the provider of medical services certifying that the recipient was delivered to the provider;

(vi) the address, or the description if the address is not available, of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

(vii) the mode of transportation in which the service is provided;

(viii) the license plate number of the vehicle used to transport the recipient;

(ix) whether the service was ambulatory or nonambulatory ~~until the modes under subdivision 17 are implemented~~;

(x) the time of the pickup and the time of the drop-off with "a.m." and "p.m." designations;

(xi) the name of the extra attendant when an extra attendant is used to provide special transportation service; and

(xii) the electronic source documentation used to calculate driving directions and mileage.

Sec. 31. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17c. **Nursing facility transports.** A Minnesota health care program enrollee residing in, or being discharged from, a licensed nursing facility is exempt from a level of need determination and is eligible for nonemergency medical transportation services until the enrollee no longer resides in a licensed nursing facility, as provided in section 256B.04, subdivision 14a.

Sec. 32. Minnesota Statutes 2016, section 256B.0625, subdivision 18h, is amended to read:

Subd. 18h. **Managed care.** (a) The following subdivisions ~~do not~~ apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs ~~(d) to (k)~~ (a), (b), (i), and (n);

(2) subdivision ~~18e~~ 18; and

(3) subdivision ~~18g~~ 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

Sec. 33. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

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. 34. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 20b. **Mental health targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

(1) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

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. 35. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

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.

Sec. 36. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance covers post-arrest community-based service coordination for an individual who:

(1) has been identified as having a mental illness or substance use disorder using a screening tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in post-arrest community-based service coordination through a diversion contract in lieu of incarceration.

(b) Post-arrest community-based service coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Post-arrest community-based service coordination must be provided by an individual who is an employee of a county or is under contract with a county to provide post-arrest community-based coordination and is qualified under one of the following criteria:

(1) a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

(2) a mental health practitioner as defined in section 245.462, subdivision 17, working under the clinical supervision of a mental health professional; or

(3) a certified peer specialist under section 256B.0615, working under the clinical supervision of a mental health professional.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of post-arrest community-based service coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under post-arrest community-based service coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the recipient's county of residence, from sources other than federal funds or funds used to match other federal funds.

EFFECTIVE DATE. This section is effective upon federal approval for services provided on or after July 1, 2017. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 37. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

Subd. 64. **Investigational drugs, biological products, and devices.** (a) Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do

not cover costs incidental to, associated with, or resulting from the use of investigational drugs, biological products, or devices as defined in section 151.375.

(b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program if all the following conditions are met:

(1) the use of stiripentol is determined to be medically necessary;

(2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating partial epilepsy in infancy due to an SCN2A genetic mutation;

(3) all other available covered prescription medications that are medically necessary for the enrollee have been tried without successful outcomes; and

(4) the United States Food and Drug Administration has approved the treating physician's individual patient investigational new drug application (IND) for the use of stiripentol for treatment.

This paragraph does not apply to MinnesotaCare coverage under chapter 256L.

Sec. 38. Minnesota Statutes 2016, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services. This section does not apply to dental service providers providing dental services outside the seven-county metropolitan area.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers providing dental services in the seven-county metropolitan area, at least ten percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

EFFECTIVE DATE. This section is effective upon receipt of any necessary federal waiver or approval. The commissioner of human services shall notify the revisor of statutes if a federal waiver or approval is sought and, if sought, when a federal waiver or approval is obtained.

Sec. 39. Minnesota Statutes 2016, section 256B.072, is amended to read:

256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.

Subdivision 1. **Performance measures.** (a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

(b) The measures used for the performance reporting system for medical groups shall include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with ~~measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines~~ section 62U.02, subdivision 1, paragraph (a), clause (1). In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may require providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a Web site suitable for this purpose.

(e) Performance measures must be stratified as provided under section 62U.02, subdivision 1, paragraph ~~(b)~~ (c), and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

(f) Notwithstanding paragraph (b), by January 1, 2019, the commissioner shall consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socioeconomically complex patient populations and request to be scored on additional measures in this subdivision. This applies to all Minnesota health care programs, including for patient populations enrolled in health plans, county-based purchasing plans, or managed care organizations and for value-based purchasing arrangements, including, but not limited to, initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and 256B.0757.

(g) Assessment of patient satisfaction with chronic pain management for the purpose of determining compensation or quality incentive payments is prohibited. The commissioner shall require managed care plans, county-based purchasing plans, and integrated health partnerships to comply with this requirement as a condition of contract. This prohibition does not apply to:

(1) assessing patient satisfaction with chronic pain management for the purpose of quality improvement; and

(2) pain management as a part of a palliative care treatment plan to treat patients with cancer or patients receiving hospice care.

Subd. 2. **Adjustment of quality metrics for special populations.** Notwithstanding subdivision 1, paragraph (b), by January 1, 2019, the commissioner shall consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socio-economically complex patient populations and request to be scored on additional measures in this subdivision. This requirement applies to all medical assistance and MinnesotaCare programs and enrollees, including persons enrolled in managed care and county-based purchasing plans or other managed care organizations, persons receiving care under fee-for-service, and persons receiving care under value-based purchasing arrangements, including but not limited to initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and 256B.0757.

Sec. 40. Minnesota Statutes 2016, section 256B.0755, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** (a) The commissioner shall ~~develop and authorize~~ continue a demonstration project established under this section to test alternative and

innovative integrated health ~~care delivery systems~~ partnerships, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for the ~~health care delivery system~~ integrated health partnership projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become ~~health care delivery systems~~ integrated health partnerships, and may be customized for the special needs and barriers of patient populations experiencing health disparities due to social, economic, racial, or ethnic factors,;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the ~~health care delivery system~~ integrated health partnership and counties and nonprofit agencies that provide services to patients enrolled with the ~~health care delivery system~~ integrated health partnership, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the ~~delivery system~~ integrated health partnership demonstrations that are appropriate for the particular patient population to be served; and

(11) encourage participation of privately insured population so as to create sufficient alignment in demonstration systems.

(c) To be eligible to participate in ~~the demonstration project~~ an integrated health partnership, a health care delivery system must:

(1) provide required covered services and care coordination to recipients enrolled in the ~~health care delivery system~~ integrated health partnership;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(d) ~~A health care delivery system~~ An integrated health partnership demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

~~A health care delivery system~~ An integrated health partnership may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

(e) The commissioner may require ~~a health care delivery system~~ an integrated health partnership to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 41. Minnesota Statutes 2016, section 256B.0755, subdivision 3, is amended to read:

Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability standards must be appropriate to the particular population served.

(b) ~~A health care delivery system~~ An integrated health partnership may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, county agencies, and rural clinics to the extent practicable.

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

Sec. 42. Minnesota Statutes 2016, section 256B.0755, subdivision 4, is amended to read:

Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery systems~~ integrated health partnerships, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in ~~a health care delivery system~~ an integrated health partnership.

(b) The payment system may include incentive payments to ~~health care delivery systems~~ integrated health partnerships that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

(d) The payment system shall include a population-based payment that supports care coordination services for all enrollees served by the integrated health partnerships, and is risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with chronic conditions, limited English skills, cultural differences, are homeless, or experience health disparities or other barriers to health care. The population-based payment shall be a per member, per month payment paid at least on a quarterly basis. Integrated health partnerships receiving this payment must continue to meet cost and quality metrics under the program to maintain eligibility for the population-based payment. An integrated health partnership is eligible to receive a payment under this paragraph even if the partnership is not participating in a risk-based or gain-sharing payment model and regardless of the size of the patient population served by the integrated health partnership. Any integrated health partnership participant certified as a health care home under section 256B.0751 that agrees to a payment method that includes population-based payments for care coordination is not eligible to receive health care home payment or care coordination fee authorized under section 62U.03 or 256B.0753, subdivision 1, or in-reach care coordination under section 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled or attributed to the integrated health partnership under this demonstration.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 43. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision to read:

Subd. 9. **Patient incentives.** The commissioner may authorize an integrated health partnership to provide incentives for patients to:

(1) see a primary care provider for an initial health assessment;

(2) maintain a continuous relationship with the primary care provider; and

(3) participate in ongoing health improvement and coordination of care activities.

Sec. 44. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision to read:

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

(1) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

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. 45. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers

necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $12,000,000 per year from Hennepin County and $6,000,000 per year from Ramsey County. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Hennepin County Medical Center or Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Hennepin County Medical Center and Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County ~~and~~, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center ~~and~~, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center ~~and~~, the city of St. Paul~~.~~, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to ~~(d)~~ (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

~~(f)~~ (g) The payments in paragraphs (a) to ~~(d)~~ (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

EFFECTIVE DATE. Paragraph (d) is effective July 1, 2017, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is received.

Sec. 46. Minnesota Statutes 2016, section 256B.196, subdivision 3, is amended to read:

Subd. 3. **Intergovernmental transfers.** Based on the determination by the commissioner under subdivision 2, Hennepin County and Ramsey County shall make periodic intergovernmental transfers to the commissioner for the purposes of subdivision 2, paragraphs (a) and (b). All of the intergovernmental transfers made by Hennepin County shall be used to match federal payments to Hennepin County Medical Center under subdivision 2, paragraph (a), and to physicians and other billing professionals affiliated with Hennepin County Medical Center under subdivision 2, paragraph (b). All of the intergovernmental transfers made by Ramsey County shall be used to match federal payments to Regions Hospital under subdivision 2, paragraph (a), and to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group under subdivision 2, paragraph (b). All of the intergovernmental transfer payments made by the University of Minnesota Medical School and the University of Minnesota School of Dentistry shall be used to match federal payments to the University of Minnesota and the University of Minnesota Physicians under subdivision 2, paragraph (e).

Sec. 47. Minnesota Statutes 2016, section 256B.196, subdivision 4, is amended to read:

Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the intergovernmental transfers under subdivision 3 and the payments under subdivision 2, based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, hospital-specific limitations on disproportionate share payments, medical inflation, actuarial certification, average commercial rates for physician and other professional services as defined in this section, and cost-effectiveness for purposes

of federal waivers. Any adjustments must be made on a proportional basis. The commissioner may make adjustments under this subdivision only after consultation with the affected counties, university schools, and hospitals. All payments under subdivision 2 and all intergovernmental transfers under subdivision 3 are limited to amounts available after all other base rates, adjustments, and supplemental payments in chapter 256B are calculated.

(b) The ratio of medical assistance payments specified in subdivision 2 to the voluntary intergovernmental transfers specified in subdivision 3 shall not be reduced except as provided under paragraph (a).

Sec. 48. Minnesota Statutes 2016, section 256B.69, subdivision 9e, is amended to read:

Subd. 9e. **Financial audits.** ~~(a)~~ The legislative auditor shall ~~conduct or contract with vendors to conduct independent third-party financial audits of the information required to be provided by~~ audit managed care plans and county-based purchasing plans ~~under subdivision 9c, paragraph (b). The audits by the vendors shall be conducted as vendor resources permit and in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the vendors shall be designed and administered so as to render the independent third-party audits eligible for a federal subsidy, if available. The contract shall require the audits to include a determination of compliance with the federal Medicaid rate certification process~~ to determine if a managed care plan or county-based purchasing plan used public money in compliance with federal and state laws, rules, and in accordance with provisions in the plan's contract with the commissioner. The legislative auditor shall conduct the audits in accordance with section 3.972, subdivision 2b.

~~(b) For purposes of this subdivision, "independent third-party" means a vendor that is independent in accordance with government auditing standards issued by the United States Government Accountability Office.~~

Sec. 49. Minnesota Statutes 2016, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on

December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2016, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility

services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 50. Minnesota Statutes 2016, section 256B.76, subdivision 1, as amended by Laws 2017, chapter 40, article 1, section 79, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June

30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by 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) Any ratables effective before July 1, 2015, do not apply to autism early intensive intervention benefits described in section 256B.0949.

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

Sec. 51. Minnesota Statutes 2016, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

(l) Effective for services provided on or after January 1, 2017, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

(m) Effective for services provided on or after July 1, 2017, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the payment increase under this paragraph.

Sec. 52. Minnesota Statutes 2016, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.

(d) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(e) Any ratables effective before July 1, 2015, do not apply to autism early intensive intervention benefits described in section 256B.0949.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 53. **[256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC HEALTH NURSE HOME VISITS.**

Effective for services provided on or after January 1, 2018, prenatal and postpartum follow-up home visits provided by public health nurses or registered nurses supervised by a public health nurse using evidence-based models shall be paid $140 per visit. Evidence-based postpartum follow-up home visits must be administered by home visiting programs that meet the United States Department of Health and Human Services criteria for evidence-based models and are identified by the commissioner of health as eligible to be implemented under the Maternal, Infant, and Early Childhood Home Visiting program. Home visits must target mothers and their children beginning with prenatal visits through age three for the child.

Sec. 54. Minnesota Statutes 2016, 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, and laboratory services 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, of which payments above the federal upper payment limit shall be state funded.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2016.

Sec. 55. Minnesota Statutes 2016, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under

section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, and nursing home or intermediate care facilities services.

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

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

(d) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 56. Minnesota Statutes 2016, section 256L.03, subdivision 1a, is amended to read:

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

Sec. 57. Minnesota Statutes 2016, section 256L.03, subdivision 5, is amended to read:

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

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

~~(2) $25 for eyeglasses for adult enrollees;~~

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

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

~~(5) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next-higher five cent increment.~~

~~(b) Paragraph (a) does~~ (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section ~~447.51~~ 600.5.

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

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

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

~~(f)~~ (b) The commissioner shall ~~increase~~ adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to ~~reduce~~ maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

~~(g)~~ (c) The cost-sharing changes authorized under paragraph ~~(f)~~ (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 58. Minnesota Statutes 2016, section 256L.11, is amended by adding a subdivision to read:

Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2018, the commissioner shall increase payment rates to

dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12 shall reflect the payment increase described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

Sec. 59. Minnesota Statutes 2016, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after July 1, ~~2016~~ 2017, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by ~~32.5~~ 20 percent above the payment rate that would otherwise be paid to the provider~~, except for a dental clinic or dental group described in section 256B.76, subdivision 4, paragraph (b), in which the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider~~. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 60. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	~~$29~~ $37
160%	170%	~~$33~~ $44
170%	180%	~~$38~~ $52
180%	190%	~~$43~~ $61
190%	200%	~~$50~~ $71
200%		$80

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 61. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2019 until July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July 31, 2019.

(b) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2021 until July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July 31, 2021.

Sec. 62. **FEDERAL WAIVER OR APPROVAL; STATE PROGRAM PARTICIPATION REQUIREMENT.**

The commissioner of human services shall seek any federal waiver or approval necessary to implement section 38.

Sec. 63. **COMPETITIVE BIDDING AND PROCUREMENT FOR CONTRACT YEAR 2019.**

(a) If the commissioner of human services decides to conduct a procurement for managed care organization contracts effective for contract year 2019, for nonelderly adults and children who are not eligible on the basis of a disability and are enrolled in medical assistance or MinnesotaCare, the commissioner shall utilize a competitive price and technical bidding process that meets the requirements described under this section. For purposes of this section, "managed care organization" means a demonstration provider as defined in Minnesota Statutes, section 256B.69, subdivision 2, paragraph (b).

(b) The commissioner shall not procure through a statewide procurement which includes all 87 counties, but shall establish geographic regions for the purpose of procurement. No geographic region shall exceed 60 percent of the total enrollment to which this section applies, except in cases when a managed care organization withdraws from their contract with the state, managed care organizations merge, other significant market changes occur within the purchasing or health care delivery system, or counties within the proposed geographic region agree to a larger procurement. The commissioner shall ensure that there is an adequate choice of managed care organizations based on the potential enrollment. The commissioner shall operate the competitive bidding program by region, but shall award contracts by county and shall allow managed care organizations with a service area consisting of only a portion of a region to only bid on those counties within their licensed service area.

(c) The commissioner shall provide the scoring weight of selection criteria to be assigned in the competitive bidding procurement process and include the scoring weight in the request for proposals. Substantial weight shall be given to county board resolutions and priority areas identified by counties, when that input meets federal requirements under Code of Federal Regulations, title 42, part 338.58.

(d) If a best and final offer is requested, each responding managed care organization must be offered the opportunity to submit a best and final offer.

(e) The commissioner, when evaluating proposals, shall consider network adequacy for dental and other services.

(f) After the managed care organizations are notified about the award determination, but before contracts are signed, the commissioner shall meet with any responder upon request to discuss their individual results in detail. No evaluation materials will be provided in writing until final contracts are signed.

(g) The commissioner shall provide information to potential responders that outlines the goals and objectives of the procurement, in advance of any publication of a request for proposals under this section.

(h) A managed care organization that is aggrieved by the commissioner's decision related to the selection of managed care organizations to deliver services in a county or counties may appeal the commissioner's decision using the process outlined in Minnesota Statutes, section 256B.69, subdivision 3a, paragraph (d).

(i) Any procurement conducted by the commissioner before January 1, 2019, must meet the requirements of this section, and a new procurement shall not be conducted for at least three years within the geographic regions included, except in cases where a managed care organization withdraws from the contract with the state, managed care organizations merge, or other significant market changes occur within the purchasing or health care delivery system, or counties within the geographic region agree to a shorter procurement time period.

Sec. 64. **OPIOID USE AND ACUPUNCTURE STUDY.**

(a) The commissioner of human services, within the limits of available appropriations, shall study the use of opiates for the treatment of chronic pain conditions when acupuncture services are also part of the treatment for chronic pain as compared to opiate use among medical assistance recipients who are not receiving acupuncture. In comparing the sample groups, the commissioner shall look at each group's opiate use and other services as identified by the commissioner.

(b) The aggregate findings of the study shall be submitted by the commissioner to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2018. The report shall not contain or disclose any patient identifying data.

Sec. 65. **STUDY OF PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES.**

The commissioner of human services shall study the impact of basing medical assistance payment for durable medical equipment and medical supplies on Medicare payment rates, as limited by the payment provisions in the 21st Century Cures Act, Public Law 114-255, on access by medical assistance enrollees to these items. The study must include recommendations for ensuring and improving access by medical assistance enrollees to durable medical equipment and medical supplies. The commissioner shall report study results and recommendations to the chairs and ranking minority members of the legislative

committees with jurisdiction over health and human services policy and finance by January 1, 2019.

Sec. 66. **ELIGIBILITY VERIFICATION FEDERAL COMPLIANCE.**

The commissioner of human services shall implement a process to terminate coverage for medical assistance enrollees who fail to submit requested verifications within 95 days of coverage approval. The commissioner shall implement a manual process by July 1, 2017, with the counties and tribal agencies, and provide them with instructions and necessary reports. The commissioner shall ensure that the Minnesota eligibility technology system (METS) has the required functionality to implement an automated process to verify eligibility by April 1, 2018.

Sec. 67. **REVISOR'S INSTRUCTION.**

The revisor of statutes, in the next edition of Minnesota Statutes, shall change the term "health care delivery system" and similar terms to "integrated health partnership" and similar terms, wherever it appears in Minnesota Statutes, section 256B.0755.

Sec. 68. **REPEALER.**

(a) Minnesota Statutes 2016, sections 256B.19, subdivision 1c; and 256B.64, are repealed.

(b) Minnesota Rules, part 9500.1140, subparts 3, 4, 5, and 6, are repealed.

ARTICLE 5

HEALTH INSURANCE

Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

Subdivision 1. **Reference.** (a) Any reference to "standard provisions" which may appear in other sections and which refer to accident and sickness or accident and health insurance shall hereinafter be construed as referring to accident and sickness policy provisions.

(b) Notwithstanding paragraph (a), the following do not apply to health plans:

(1) subdivision 2, clauses (5) to (10) and (12);

(2) subdivision 3, clauses (1) and (3) to (7); and

(3) subdivisions 6 and 10.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's ~~former spouse and~~ dependent children ~~upon~~, which is defined as required by section 62A.302, and former spouse, who was covered on the day before the entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the insured's former spouse becomes covered under any other group health plan; or

(b) the date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Upon request by the insured's former spouse, who was covered on the day before the entry of a valid decree of dissolution, or dependent child, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 3. Minnesota Statutes 2016, section 62A.3075, is amended to read:

62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.

(a) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than what the health plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health plan company.

(b) A health plan company must not achieve compliance with this section by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan.

(c) Nothing in this section shall be interpreted to prohibit a health plan company from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

(d) A plan offered by the commissioner of management and budget under section 43A.23 is deemed to be at parity and in compliance with this section.

(e) A health plan company is in compliance with this section if it does not include orally administered anticancer medication in the fourth tier of its pharmacy benefit.

(f) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment must indicate the level of coverage for orally administered anticancer medication within its pharmacy benefit filing with the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2016, section 62D.105, is amended to read:

62D.105 COVERAGE OF CURRENT SPOUSE, FORMER SPOUSE, AND CHILDREN.

Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to covering the enrollee also provides coverage to the spouse ~~and~~, dependent children, which is defined as required by section 62A.302, and former spouse who was covered on the day before the entry of a valid decree of dissolution of marriage, of the enrollee shall: (1) permit the spouse, former spouse, and dependent children to elect to continue coverage when the enrollee becomes enrolled for benefits under title XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the contract;

(2) 36 months after continuation by the spouse, former spouse, or dependent was elected; or

(3) the date the spouse, former spouse, or dependent children become covered under another group health plan or Medicare.

If coverage is provided under a group policy, any required fees for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder for remittance to the health maintenance organization. In no event shall the fee charged exceed 102 percent of the cost to the plan for such coverage for other similarly situated spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 5. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

Subd. 11. ~~**Essential health benefits package**~~ **Affordable Care Act compliant plans.** For ~~individual or small group health plans that include the essential health benefits package and are~~ any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, ~~2014~~ 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 6. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage, except Medicare supplement policies, shall be labeled as "qualified" or "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified plans shall indicate whether they are number one, two, or three coverage plans. For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 7. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to read:

Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 8. Laws 2017, chapter 2, article 1, section 5, is amended to read:

Sec. 5. **SUNSET.**

This article ~~sunsets June 30~~, other than section 2, subdivision 5; section 3; and section 7, sunsets August 31, 2018.

Sec. 9. Laws 2017, chapter 2, article 1, section 7, is amended to read:

Sec. 7. **APPROPRIATIONS.**

(a) $311,788,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of management and budget for premium assistance under section 2. This appropriation is onetime and is available through ~~June 30~~ August 31, 2018.

(b) $157,000 in fiscal year 2017 is appropriated from the general fund to the legislative auditor for purposes of section 3. This appropriation is onetime.

(c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018, shall be transferred ~~on July 1~~ no later than August 31, 2018, from the general fund to the budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

Sec. 10. Laws 2017, chapter 13, article 1, section 15, 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 ~~general fund amount~~ state funds not used for the Minnesota premium security plan by June 30, 2021, to the commissioner of commerce. Any amount transferred to the commissioner of commerce shall be deposited in the ~~general fund.~~

~~(c) The association shall transfer from the premium security plan account any health care access fund amount not used for the Minnesota premium security plan by June 30, 2021, 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.

~~(d)~~ (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. 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 health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may only merge or consolidate with; or convert, or transfer all or a substantial portion of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A.

(b) Paragraph (a) does not apply if the service plan corporation or 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 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.

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

ARTICLE 6

DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2016, section 252.50, subdivision 5, is amended to read:

Subd. 5. **Location of programs.** (a) In determining the location of state-operated, community-based programs, the needs of the individual client shall be paramount. The commissioner shall also take into account:

(1) prioritization of beds in state-operated, community-based programs for individuals with complex behavioral needs that cannot be met by private community-based providers;

(2) choices made by individuals who chose to move to a more integrated setting, and shall coordinate with the lead agency to ensure that appropriate person-centered transition plans are created;

(3) the personal preferences of the persons being served and their families as determined by Minnesota Rules, parts 9525.0004 to 9525.0036;

~~(2)~~ (4) the location of the support services established by the individual service plans of the persons being served;

~~(3)~~ (5) the appropriate grouping of the persons served;

~~(4)~~ (6) the availability of qualified staff;

~~(5)~~ (7) the need for state-operated, community-based programs in the geographical region of the state; and

~~(6)~~ (8) a reasonable commuting distance from a regional treatment center or the residences of the program staff.

(b) State-operated, community-based programs must be located according to section 252.28.

Sec. 2. Minnesota Statutes 2016, section 253B.10, subdivision 1, is amended to read:

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The commissioner shall prioritize patients being admitted from jail or a correctional institution who are:

(1) ordered confined in a state hospital for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

(2) under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

(3) found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a state hospital or other facility pending completion of the civil commitment proceedings; or

(4) committed under this chapter to the commissioner after dismissal of the patient's criminal charges.

Patients described in this paragraph must be admitted to a service operated by the commissioner within 48 hours. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (c).

(c) Upon the arrival of a patient at the designated treatment facility, the head of the facility shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the treatment facility.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the examiners, and the prepetition report shall be provided promptly to the treatment facility. This information shall also be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws.

Sec. 3. **REVIEW OF ALTERNATIVES TO STATE-OPERATED GROUP HOMES HOUSING ONE PERSON.**

The commissioner of human services shall review the potential for, and the viability of, alternatives to state-operated group homes housing one person. The intent is to create housing options for individuals who do not belong in an institutionalized setting, but need additional support before transitioning to a more independent community placement. The review shall include an analysis of existing housing settings operated by counties and private providers, as well as the potential for new housing settings, and determine the viability for use by state-operated services. The commissioner shall seek input from interested stakeholders as part of the review. An update, including alternatives identified, will be provided by the

commissioner to the members of the legislative committees having jurisdiction over human services issues no later than January 15, 2018.

ARTICLE 7

CHILDREN AND FAMILIES

Section 1. Minnesota Statutes 2016, section 13.32, is amended by adding a subdivision to read:

Subd. 12. **Access by welfare system.** County personnel in the welfare system may request access to education data in order to coordinate services for a student or family. The request must be submitted to the chief administrative officer of the school and must include the basis for the request and a description of the information that is requested. The chief administrative officer must provide a copy of the request to the parent or legal guardian of the student who is the subject of the request, along with a form the parent or legal guardian may execute to consent to the release of specified information to the requester. Education data may be released under this subdivision only if the parent or legal guardian gives informed consent to the release.

Sec. 2. Minnesota Statutes 2016, section 13.46, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** As used in this section:

(a) "Individual" means an individual according to section 13.02, subdivision 8, but does not include a vendor of services.

(b) "Program" includes all programs for which authority is vested in a component of the welfare system according to statute or federal law, including, but not limited to, Native American tribe programs that provide a service component of the welfare system, the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, Minnesota family investment program, temporary assistance for needy families program, medical assistance, general assistance, general assistance medical care formerly codified in chapter 256D, child care assistance program, and child support collections.

(c) "Welfare system" includes the Department of Human Services, local social services agencies, county welfare agencies, county public health agencies, county veteran services agencies, county housing agencies, private licensing agencies, the public authority responsible for child support enforcement, human services boards, community mental health center boards, state hospitals, state nursing homes, the ombudsman for mental health and developmental disabilities, Native American tribes to the extent a tribe provides a service

component of the welfare system, and persons, agencies, institutions, organizations, and other entities under contract to any of the above agencies to the extent specified in the contract.

(d) "Mental health data" means data on individual clients and patients of community mental health centers, established under section 245.62, mental health divisions of counties and other providers under contract to deliver mental health services, or the ombudsman for mental health and developmental disabilities.

(e) "Fugitive felon" means a person who has been convicted of a felony and who has escaped from confinement or violated the terms of probation or parole for that offense.

(f) "Private licensing agency" means an agency licensed by the commissioner of human services under chapter 245A to perform the duties under section 245A.16.

Sec. 3. Minnesota Statutes 2016, 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 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; ~~or~~

(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.

Sec. 4. Minnesota Statutes 2016, section 13.84, subdivision 5, is amended to read:

Subd. 5. **Disclosure.** Private or confidential court services data shall not be disclosed except:

(a) pursuant to section 13.05;

(b) pursuant to a statute specifically authorizing disclosure of court services data;

(c) with the written permission of the source of confidential data;

(d) to the court services department, parole or probation authority or state or local correctional agency or facility having statutorily granted supervision over the individual subject of the data, or to county personnel within the welfare system;

(e) pursuant to subdivision 6;

(f) pursuant to a valid court order; or

(g) pursuant to section 611A.06, subdivision 3a.

Sec. 5. Minnesota Statutes 2016, 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 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 October 23, 2017.

Sec. 6. Minnesota Statutes 2016, section 119B.011, subdivision 20a, is amended to read:

Subd. 20a. **Transition year extension families.** "Transition year extension families" means families who have completed their transition year of child care assistance under this subdivision and who are eligible for, but on a waiting list for, services under section 119B.03. For purposes of sections 119B.03, subdivision 3, and 119B.05, subdivision 1, clause (2), families participating in extended transition year shall not be considered transition year families. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year extension child care may be used to support employment, approved education or training programs, or a job search that meets the requirements of section 119B.10 for the length of time necessary for families to be moved from the basic sliding fee waiting list into the basic sliding fee program.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 7. Minnesota Statutes 2016, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. ~~**Factors which must be verified**~~ **Applications.** (a) 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) ~~If a family did not use the universal application or child care addendum to apply for child care assistance, the family must complete the universal application or child care addendum at its next eligibility redetermination and the county must verify the factors listed in paragraph (a) as part of that redetermination. Once a family has completed a universal application or child care addendum, the county shall use the redetermination form described in paragraph (c) for that family's subsequent redeterminations. Eligibility must be redetermined at least every six months. A family is considered to have met the eligibility redetermination requirement if a complete redetermination form and all required verifications are received within 30 days after the date the form was due. When the 30th day after the date the form was due falls on a Saturday, Sunday, or legal holiday, the 30-day time period is extended to include the next succeeding day that is not a Saturday, Sunday, or legal holiday. Assistance shall be payable retroactively from the redetermination due date. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year. If a family reports a change in an eligibility factor before the family's next regularly scheduled redetermination, the county must recalculate eligibility without requiring verification of any eligibility factor that did not change. Changes must be reported as required by section 256P.07. A change in income occurs on the day the participant received the first payment reflecting the change in income.~~ 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) The commissioner shall develop a redetermination form to redetermine eligibility and a change report form to report changes that minimize paperwork for the county and the participant.~~

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 8. Minnesota Statutes 2016, section 119B.025, is amended by adding a subdivision to read:

Subd. 3. **Redeterminations.** (a) Notwithstanding Minnesota Rules, part 3400.0180, item A, the county shall conduct a redetermination according to paragraphs (b) and (c).

(b) The county shall use the redetermination form developed by the commissioner. The county must verify the factors listed in subdivision 1, paragraph (a), as part of the redetermination.

(c) An applicant's eligibility must be redetermined no more frequently than every 12 months. The following criteria apply:

(1) a family meets the eligibility redetermination requirements if a complete redetermination form and all required verifications are received within 30 days after the date the form was due;

(2) if the 30th day after the date the form was due falls on a Saturday, Sunday, or holiday, the 30-day time period is extended to include the next day that is not a Saturday, Sunday, or holiday. Assistance shall be payable retroactively from the redetermination due date;

(3) for a family where at least one parent is younger than 21 years of age, does not have a high school degree or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility may be deferred beyond 12 months, to the end of the student's school year; and

(4) a family and the family's providers must be notified that the family's redetermination is due at least 45 days before the end of the family's 12-month eligibility period.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 9. Minnesota Statutes 2016, section 119B.025, is amended by adding a subdivision to read:

Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility factors according to paragraphs (b) to (g).

(b) A family is subject to the reporting requirements in section 256P.07.

(c) If a family reports a change or a change is known to the agency before the family's regularly scheduled redetermination, the county must act on the change. The commissioner shall establish standards for verifying a change.

(d) A change in income occurs on the day the participant received the first payment reflecting the change in income.

(e) During a family's 12-month eligibility period, if the family's income increases and remains at or below 85 percent of the state median income, adjusted for family size, there is no change to the family's eligibility. The county shall not request verification of the change. The co-payment fee shall not increase during the remaining portion of the family's 12-month eligibility period.

(f) During a family's 12-month eligibility period, if the family's income increases and exceeds 85 percent of the state median income, adjusted for family size, the family is not eligible for child care assistance. The family must be given 15 calendar days to provide verification of the change. If the required verification is not returned or confirms ineligibility, the family's eligibility ends following a subsequent 15-day adverse action notice.

(g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170, subpart 1, if an applicant or participant reports that employment ended, the agency may accept a signed statement from the applicant or participant as verification that employment ended.

EFFECTIVE DATE. Paragraphs (a) and (b) are effective the day following final enactment. Paragraphs (c) to (g) are effective October 23, 2017.

Sec. 10. Minnesota Statutes 2016, section 119B.03, subdivision 3, is amended to read:

Subd. 3. **Eligible participants.** Families that meet the eligibility requirements under sections ~~119B.07,~~ 119B.09~~,~~ and 119B.10, except MFIP participants, diversionary work program, and transition year families are eligible for child care assistance under the basic sliding fee program. Families enrolled in the basic sliding fee program shall be continued

until they are no longer eligible. Child care assistance provided through the child care fund is considered assistance to the parent.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 11. Minnesota Statutes 2016, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

(7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2;

(8) families who are participating in the transition year extension under section 119B.011, subdivision 20a; ~~and~~

(9) student parents as defined under section 119B.011, subdivision 19b~~.~~; and

(10) student parents who turn 21 years of age and who continue to meet the other requirements under section 119B.011, subdivision 19b. A student parent continues to be eligible until the student parent is approved for basic sliding fee child care assistance or until the student parent's redetermination, whichever comes first. At the student parent's redetermination, if the student parent was not approved for basic sliding fee child care assistance, a student parent's eligibility ends following a 15-day adverse action notice.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 12. Minnesota Statutes 2016, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements ~~for all applicants for child care assistance.~~** (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 ~~program entry~~ application and less than or equal to 67 percent of the state median income, adjusted for family size, at ~~program exit~~ 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.

EFFECTIVE DATE. Paragraphs (a) and (c) are effective October 23, 2017. Paragraph (d) is effective the day following final enactment.

Sec. 13. Minnesota Statutes 2016, section 119B.09, subdivision 4, is amended to read:

Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant family is the current monthly income of the family multiplied by 12 or the income for the 12-month period immediately preceding the date of application, or income calculated by the method which provides the most accurate assessment of income available to the family.

(b) Self-employment income must be calculated based on gross receipts less operating expenses. ~~Income must be recalculated when the family's income changes, but no less often than every six months. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, income must be recalculated when the family's income changes, but otherwise shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year.~~

(c) Income changes are processed under section 119B.025, subdivision 4. Included lump sums counted as income under section 256P.06, subdivision 3, must be annualized over 12 months. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 14. **[119B.095] CHILD CARE AUTHORIZATIONS.**

Subdivision 1. **General authorization requirements.** (a) When authorizing the amount of child care, the county agency must consider the amount of time the parent reports on the application or redetermination form that the child attends preschool, a Head Start program, or school while the parent is participating in an authorized activity.

(b) Care must be authorized and scheduled with a provider based on the applicant's or participant's verified activity schedule when:

(1) the family requests care from more than one provider per child;

(2) the family requests care from a legal nonlicensed provider; or

(3) an applicant or participant is employed by any child care center that is licensed by the Department of Human Services or has been identified as a high-risk Medicaid-enrolled provider.

(c) If the family remains eligible at redetermination, a new authorization with fewer hours, the same hours, or increased hours may be determined.

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).

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 15. **[119B.097] AUTHORIZATION WITH A SECONDARY PROVIDER.**

(a) If a child uses any combination of the following providers paid by child care assistance, a parent must choose one primary provider and one secondary provider per child that can be paid by child care assistance:

(1) an individual or child care center licensed under chapter 245A;

(2) an individual or child care center or facility holding a valid child care license issued by another state or tribe; or

(3) a child care center exempt from licensing under section 245A.03.

(b) The amount of child care authorized with the secondary provider cannot exceed 20 hours per two-week service period, per child, and the amount of care paid to a child's secondary provider is limited under section 119B.13, subdivision 1. The total amount of child care authorized with both the primary and secondary provider cannot exceed the amount of child care allowed based on the parents' eligible activity schedule, the child's school schedule, and any other factors relevant to the family's child care needs.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 16. Minnesota Statutes 2016, section 119B.10, subdivision 1, is amended to read:

Subdivision 1. **Assistance for persons seeking and retaining employment.** (a) Persons who are seeking employment and who are eligible for assistance under this section are eligible to receive up to 240 hours of child care assistance per calendar year.

(b) At application and redetermination, employed persons who work at least an average of 20 hours and full-time students who work at least an average of ten hours a week and receive at least a minimum wage for all hours worked are eligible for ~~continued~~ child care assistance for employment. For purposes of this section, work-study programs must be counted as employment. An employed person with an MFIP or DWP employment plan shall receive child care assistance as specified in the person's employment plan. Child care assistance during employment must be authorized as provided in paragraphs (c) and (d).

(c) When the person works for an hourly wage and the hourly wage is equal to or greater than the applicable minimum wage, child care assistance shall be provided for the ~~actual~~ hours of employment, break, and mealtime during the employment and travel time up to two hours per day.

(d) When the person does not work for an hourly wage, child care assistance must be provided for the lesser of:

(1) the amount of child care determined by dividing gross earned income by the applicable minimum wage, up to one hour every eight hours for meals and break time, plus up to two hours per day for travel time; or

(2) the amount of child care equal to the actual amount of child care used during employment, including break and mealtime during employment, and travel time up to two hours per day.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 17. Minnesota Statutes 2016, section 119B.10, is amended by adding a subdivision to read:

Subd. 3. **Assistance for persons attending an approved education or training program.** (a) Money for an eligible person according to sections 119B.03, subdivision 3, and 119B.05, subdivision 1, shall be used to reduce child care costs for a student. The county shall not limit the duration of child care subsidies for a person in an employment or

educational program unless the person is ineligible for child care funds. Any other limitation must be based on county policies included in the approved child care fund plan.

(b) To be eligible, the student must be in good standing and be making satisfactory progress toward the degree. The maximum length of time a student is eligible for child care assistance under the child care fund for education and training is no more than the time necessary to complete the credit requirements for an associate's or baccalaureate degree as determined by the educational institution. Time limitations for child care assistance do not apply to basic or remedial educational programs needed for postsecondary education or employment. Basic or remedial educational programs include high school, general equivalency diploma, and English as a second language programs. A program exempt from this time limit must not run concurrently with a postsecondary program.

(c) If a student meets the conditions of paragraphs (a) and (b), child care assistance must be authorized for all hours of class time and credit hours, including independent study and internships, and up to two hours of travel time per day. A postsecondary student shall receive four hours of child care assistance per credit hour for study time and academic appointments per service period.

(d) For an MFIP or DWP participant, child care assistance must be authorized according to the person's approved employment plan. If an MFIP or DWP participant receiving MFIP or DWP child care assistance under this chapter moves to another county, continues to participate in an authorized educational or training program, and remains eligible for MFIP or DWP child care assistance, the participant must receive continued child care assistance from the county responsible for the person's current employment plan under section 256G.07.

(e) If a person with an approved education program under section 119B.03, subdivision 3, or 119B.05, subdivision 1, begins receiving MFIP or DWP assistance, the person continues to receive child care assistance for the approved education program until the person's education is included in an approved MFIP or DWP employment plan or until redetermination, whichever occurs first.

(f) If a person's MFIP or DWP assistance ends and the approved MFIP or DWP employment plan included education, the person continues to be eligible for child care assistance for education under transition year child care assistance until the person's education is included in an approved education plan or until redetermination.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 18. **[119B.105] EXTENDED ELIGIBILITY AND AUTHORIZATION.**

Subdivision 1. **Three-month extended eligibility period.** (a) A family in a situation under paragraph (b) continues to be eligible for up to three months or until the family's redetermination, whichever occurs first, rather than losing eligibility or having the family's eligibility suspended. During extended eligibility, the amount of child care authorized shall continue at the same number or more hours. The family must continue to meet all other eligibility requirements under this chapter.

(b) The family's three-month extended eligibility period applies when:

(1) a participant's employment or education program ends permanently;

(2) the other parent moves in and does not participate in an authorized activity;

(3) a participant's MFIP assistance ends and the participant is not participating in an authorized activity or the participant's participation in an authorized activity is unknown;

(4) a student parent under section 119B.011, subdivision 19b, stops attending school; or

(5) a participant receiving basic sliding fee child care assistance or transition year child care assistance applied for MFIP assistance and is not participating in an authorized activity or the participant's participation in an authorized activity is unknown.

Subd. 2. **Extended eligibility and redetermination.** (a) If the family received three months of extended eligibility and redetermination is not due, to continue receiving child care assistance the participant must be employed or have an education plan that meets the requirements of section 119B.10, subdivision 3, or have an MFIP or DWP employment plan. If child care assistance continues, the amount of child care authorized shall continue at the same number or more hours until redetermination, unless a condition in section 119B.095, subdivision 2, paragraph (c), applies. A family subject to section 119B.095, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.

(b) If the family's redetermination occurs before the end of the three-month extended eligibility period to continue receiving child care assistance, the participant must verify that the participant meets eligibility and activity requirements for child care assistance under this chapter. If child care assistance continues, the amount of child care authorized is based on section 119B.10. A family subject to section 119B.095, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 19. Minnesota Statutes 2016, section 119B.12, subdivision 2, is amended to read:

Subd. 2. **Parent fee.** A family must be assessed a parent fee for each service period. A family's parent fee must be a fixed percentage of its annual gross income. Parent fees must apply to families eligible for child care assistance under sections 119B.03 and 119B.05. Income must be as defined in section 119B.011, subdivision 15. The fixed ~~percent~~ percentage is based on the relationship of the family's annual gross income to 100 percent of the annual state median income. Parent fees must begin at 75 percent of the poverty level. The minimum parent fees for families between 75 percent and 100 percent of poverty level must be $2 per biweekly period. Parent fees must provide for graduated movement to full payment. At initial application, the parent fee is established for the family's 12-month eligibility period. At redetermination, if the family remains eligible, the parent fee is recalculated and is established for the next 12-month eligibility period. A parent fee shall not increase during the 12-month eligibility period. Payment of part or all of a family's parent fee directly to the family's child care provider on behalf of the family by a source other than the family shall not affect the family's eligibility for child care assistance, and the amount paid shall be excluded from the family's income. Child care providers who accept third-party payments must maintain family specific documentation of payment source, amount, and time period covered by the payment.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 20. Minnesota Statutes 2016, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning February 3, 2014, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the 2011 child care provider rate survey or the maximum rate effective November 28, 2011. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

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

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum

established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(d) If a child uses one provider, the maximum payment ~~to a provider~~ for one day of care must not exceed the daily rate. The maximum payment ~~to a provider~~ for one week of care must not exceed the weekly rate.

(e) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

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

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

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

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

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2018. Paragraphs (d) to (i) are effective April 23, 2018.

Sec. 21. Minnesota Statutes 2016, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) The provider shall bill for services provided within ten days of the end of the service period. ~~If bills are submitted within ten days of the end of the service period,~~ Payments under the child care fund shall be made within ~~30~~ 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.

(e) For purposes of paragraph (d), clauses (3), (5), and (6), 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 September 25, 2017.

Sec. 22. Minnesota Statutes 2016, section 245.814, is amended by adding a subdivision to read:

Subd. 5. **Foster care parent liability insurance.** The commissioner may use federal reimbursement money earned on an expenditure for foster care parent liability insurance premiums to offset the costs of the premiums.

Sec. 23. Minnesota Statutes 2016, section 245A.50, subdivision 5, is amended to read:

Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a) License holders must document that before staff persons, caregivers, and helpers assist in the care of 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, caregivers, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.

(b) Sudden unexpected infant death reduction training required under this subdivision must, at a minimum, 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) Abusive head trauma training required under this subdivision must, at a minimum, address the risk factors related to shaking infants and young children, means of reducing the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

(d) Training for family and group family child care providers must be developed by the commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved by the Minnesota Center for Professional Development. Sudden unexpected infant death

reduction training and abusive head trauma training may be provided in a single course of no more than two hours in length.

(e) Sudden unexpected infant death reduction training and abusive head trauma training required under this subdivision must be completed in person or as allowed under subdivision 10, clause (1) or (2), at least once every two years. On the years when the license holder is not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the license holder must receive sudden unexpected infant death reduction training and abusive head trauma training through a video of no more than one hour in length. The video must be developed or approved by the commissioner.

(f) An individual who is related to the license holder as defined in section 245A.02, subdivision 13, and who is involved only in the care of the license holder's own infant or child under school age and who is not designated to be a caregiver, helper, or substitute, as defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the sudden unexpected infant death and abusive head trauma training.

Sec. 24. Minnesota Statutes 2016, 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 ~~2.23~~ 1.94 percent of adjusted gross income at 275 percent of federal poverty guidelines and increases to ~~6.08~~ 5.29 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 ~~6.08~~ 5.29 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 ~~6.08~~ 5.29 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ~~8.1~~ 7.05 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 ~~10.13~~ 8.81 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.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 25. Minnesota Statutes 2016, section 256E.30, subdivision 2, is amended to read:

Subd. 2. **Allocation of money.** (a) State money appropriated and community service block grant money allotted to the state and all money transferred to the community service block grant from other block grants shall be allocated annually to community action agencies and Indian reservation governments under clauses (b) and (c), and to migrant and seasonal farmworker organizations under clause (d).

(b) The available annual money will provide base funding to all community action agencies and the Indian reservations. Base funding amounts per agency are as follows: for agencies with low income populations up to ~~3,999~~ 1,999, $25,000; ~~4,000~~ 2,000 to 23,999, $50,000; and 24,000 or more, $100,000.

(c) All remaining money of the annual money available after the base funding has been determined must be allocated to each agency and reservation in proportion to the size of the poverty level population in the agency's service area compared to the size of the poverty level population in the state.

(d) Allocation of money to migrant and seasonal farmworker organizations must not exceed three percent of the total annual money available. Base funding allocations must be made for all community action agencies and Indian reservations that received money under this subdivision, in fiscal year 1984, and for community action agencies designated under this section with a service area population of 35,000 or greater.

Sec. 26. Minnesota Statutes 2016, section 256J.45, subdivision 2, is amended to read:

Subd. 2. **General information.** The MFIP orientation must consist of a presentation that informs caregivers of:

(1) the necessity to obtain immediate employment;

(2) the work incentives under MFIP, including the availability of the federal earned income tax credit and the Minnesota working family tax credit;

(3) the requirement to comply with the employment plan and other requirements of the employment and training services component of MFIP, including a description of the range of work and training activities that are allowable under MFIP to meet the individual needs of participants;

(4) the consequences for failing to comply with the employment plan and other program requirements, and that the county agency may not impose a sanction when failure to comply is due to the unavailability of child care or other circumstances where the participant has good cause under subdivision 3;

(5) the rights, responsibilities, and obligations of participants;

(6) the types and locations of child care services available through the county agency;

(7) the availability and the benefits of the early childhood health and developmental screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

(8) the caregiver's eligibility for transition year child care assistance under section 119B.05;

(9) the availability of all health care programs, including transitional medical assistance;

(10) the caregiver's option to choose an employment and training provider and information about each provider, including but not limited to, services offered, program components, job placement rates, job placement wages, and job retention rates;

(11) the caregiver's option to request approval of an education and training plan according to section 256J.53;

(12) the work study programs available under the higher education system; ~~and~~

(13) information about the 60-month time limit exemptions under the family violence waiver and referral information about shelters and programs for victims of family violence~~.~~; and

(14) information about the income exclusions under section 256P.06, subdivision 2.

EFFECTIVE DATE. This section is effective December 1, 2018.

Sec. 27. **[256N.261] SUPPORT FOR ADOPTIVE, FOSTER, AND KINSHIP FAMILIES.**

Subdivision 1. **Program established.** The commissioner shall design and implement a coordinated program to reduce the need for placement changes or out-of-home placements of children and youth in foster care, adoptive placements, and permanent physical and legal custody kinship placements, and to improve the functioning and stability of these families. To the extent federal funds are available, the commissioner shall provide the following adoption and foster care-competent services and ensure that placements are trauma-informed and child and family-centered:

(1) a program providing information, referrals, a parent-to-parent support network, peer support for youth, family activities, respite care, crisis services, educational support, and mental health services for children and youth in adoption, foster care, and kinship placements and adoptive, foster, and kinship families in Minnesota;

(2) training offered statewide in Minnesota for adoptive and kinship families, and training for foster families, and the professionals who serve the families, on the effects of trauma, common disabilities of adopted children and children in foster care, and kinship placements, and challenges in adoption, foster care, and kinship placements; and

(3) periodic evaluation of these services to ensure program effectiveness in preserving and improving the success of adoptive, foster, and kinship placements.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Child and family-centered" means individualized services that respond to a child's or youth's strengths, interests, and current developmental stage, including social, cognitive, emotional, physical, cultural, racial, and spiritual needs, and offer support to the entire adoptive, foster, or kinship family.

(c) "Trauma-informed" means care that acknowledges the effect trauma has on children and the children's families; modifies services to respond to the effects of trauma; emphasizes skill and strength-building rather than symptom management; and focuses on the physical and psychological safety of the child and family.

Sec. 28. Minnesota Statutes 2016, section 256P.06, subdivision 2, is amended to read:

Subd. 2. **Exempted individuals.** (a) The following members of an assistance unit under chapters 119B and 256J are exempt from having their earned income count towards the income of an assistance unit:

(1) children under six years old;

(2) caregivers under 20 years of age enrolled at least half-time in school; and

(3) minors enrolled in school full time.

(b) The following members of an assistance unit are exempt from having their earned and unearned income count towards the income of an assistance unit for 12 consecutive calendar months, beginning the month following the marriage date, for benefits under chapter 256J if the household income does not exceed 275 percent of the federal poverty guideline:

(1) a new spouse to a caretaker in an existing assistance unit; and

(2) the spouse designated by a newly married couple, both of whom were already members of an assistance unit under chapter 256J.

(c) If members identified in paragraph (b) also receive assistance under section 119B.05, they are exempt from having their earned and unearned income count towards the income of the assistance unit if the household income prior to the exemption does not exceed 67 percent of the state median income for recipients for 26 consecutive biweekly periods beginning the second biweekly period after the marriage date.

EFFECTIVE DATE. This section is effective December 1, 2018.

Sec. 29. Minnesota Statutes 2016, section 256P.07, subdivision 3, is amended to read:

Subd. 3. **Changes that must be reported.** An assistance unit must report the changes or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur, at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An assistance unit must report other changes at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section

119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report:

(1) a change in earned income of $100 per month or greater with the exception of a program under chapter 119B;

(2) a change in unearned income of $50 per month or greater with the exception of a program under chapter 119B;

(3) a change in employment status and hours with the exception of a program under chapter 119B;

(4) a change in address or residence;

(5) a change in household composition with the exception of programs under chapter 256I;

(6) a receipt of a lump-sum payment with the exception of a program under chapter 119B;

(7) an increase in assets if over $9,000 with the exception of programs under chapter 119B;

(8) a change in citizenship or immigration status;

(9) a change in family status with the exception of programs under chapter 256I;

(10) a change in disability status of a unit member, with the exception of programs under chapter 119B;

(11) a new rent subsidy or a change in rent subsidy with the exception of a program under chapter 119B; and

(12) a sale, purchase, or transfer of real property with the exception of a program under chapter 119B.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 30. Minnesota Statutes 2016, section 256P.07, subdivision 6, is amended to read:

Subd. 6. **Child care assistance programs-specific reporting.** (a) In addition to subdivision 3, an assistance unit under chapter 119B, within ten days of the change, must report:

(1) a change in a parentally responsible individual's ~~visitation schedule or~~ custody ~~arrangement~~ schedule for any child receiving child care assistance program benefits; ~~and~~

(2) a ~~change in~~ permanent end in a parentally responsible individual's authorized activity ~~status.~~; and

(3) if the unit's family's annual included income exceeds 85 percent of the state median income, adjusted for family size.

(b) An assistance unit subject to section 119B.095, subdivision 1, paragraph (b), must report a change in the unit's authorized activity status.

(c) An assistance unit must notify the county when the unit wants to reduce the number of authorized hours for children in the unit.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 31. Minnesota Statutes 2016, section 260C.451, subdivision 6, is amended to read:

Subd. 6. **Reentering foster care and accessing services after 18 years of age and up to 21 years of age.** (a) Upon request of an individual who had been under the guardianship of the commissioner and who has left foster care without being adopted, the responsible social services agency which had been the commissioner's agent for purposes of the guardianship shall develop with the individual a plan to increase the individual's ability to live safely and independently using the plan requirements of section 260C.212, subdivision 1, paragraph (c), clause (12), and to assist the individual to meet one or more of the eligibility criteria in subdivision 4 if the individual wants to reenter foster care. The responsible social services agency shall provide foster care as required to implement the plan. The responsible social services agency shall enter into a voluntary placement agreement under section 260C.229 with the individual if the plan includes foster care.

(b) Individuals who had not been under the guardianship of the commissioner of human services prior to 18 years of age may ask to reenter foster care after age 18 and~~, to the extent funds are available,~~ the responsible social services agency that had responsibility for planning for the individual before discharge from foster care ~~may~~ shall provide foster care or other services to the individual for the purpose of increasing the individual's ability to live safely and independently and to meet the eligibility criteria in subdivision 3a, if the individual:

(1) was in foster care for the six consecutive months prior to the person's 18th birthday, or left foster care within six months prior to the person's 18th birthday, and was not discharged home, adopted, or received into a relative's home under a transfer of permanent legal and physical custody under section 260C.515, subdivision 4; or

(2) was discharged from foster care while on runaway status after age 15.

(c) In conjunction with a qualifying and eligible individual under paragraph (b) and other appropriate persons, the responsible social services agency shall develop a specific plan related to that individual's vocational, educational, social, or maturational needs and~~,~~ ~~to the extent funds are available,~~ provide foster care as required to implement the plan. The responsible social services agency shall enter into a voluntary placement agreement with the individual if the plan includes foster care.

(d) A child who left foster care while under guardianship of the commissioner of human services retains eligibility for foster care for placement at any time prior to 21 years of age.

Sec. 32. **MINNESOTA BIRTH TO AGE EIGHT PILOT PROJECT.**

Subdivision 1. **Authorization.** The commissioner of human services shall award a grant to Dakota County to develop and implement pilots that will evaluate the impact of a coordinated systems and service delivery approach on key developmental milestones and outcomes that ultimately lead to reading proficiency by age eight within the target population. The pilot program is from July 1, 2017, to June 30, 2021.

Subd. 2. **Pilot design and goals.** The pilot will establish five key developmental milestone markers from birth to age eight. Enrollees in the pilot will be developmentally assessed and tracked by a technology solution that tracks developmental milestones along the established developmental continuum. If a child's progress falls below established milestones and the weighted scoring, the coordinated service system will focus on identified areas of concern, mobilize appropriate supportive services, and offer services to identified children and their families.

Subd. 3. **Program participants in phase 1 target population.** Pilot program participants must:

(1) be enrolled in a Women's Infant & Children (WIC) program;

(2) be participating in a family home visiting program, or nurse family practice, or Healthy Families America (HFA);

(3) be children and families qualifying for and participating in early language learners (ELL) in the school district in which they reside; and

(4) opt in and provide parental consent to participate in the pilot project.

Subd. 4. **Evaluation and report.** The county or counties shall work with a third-party evaluator to evaluate the effectiveness of the pilot and report to the legislative committees

with jurisdiction over human services policy and finance each year by February 1 with an update on the progress of the pilot. The final report on the pilot is due January 1, 2022.

Sec. 33. **MINNESOTA PATHWAYS TO PROSPERITY AND WELL-BEING PILOT PROJECT.**

Subdivision 1. **Authorization.** The commissioner of human services may develop a pilot project that shall test an alternative financing model for the distribution of publicly funded benefits. The commissioner may work with interested counties to develop the pilot and determine the waivers that are necessary to implement the pilot project based on the pilot design in subdivisions 2 and 3, and outcome measures in subdivision 4.

Subd. 2. **Pilot project goals.** The goals of the pilot project are to:

(1) reduce the historical separation among the state programs and systems affecting families who are receiving public assistance;

(2) eliminate, where possible, funding restrictions to allow a more comprehensive approach to the needs of the families in the pilot project; and

(3) focus on upstream, prevention-oriented supports and interventions.

Subd. 3. **Project participants.** The pilot project developed by the commissioner may include requirements that participants:

(1) be 26 years of age or younger with a minimum of one child;

(2) voluntarily agree to participate in the pilot project;

(3) be eligible for, applying for, or receiving public benefits including but not limited to housing assistance, education supports, employment supports, child care, transportation supports, medical assistance, earned income tax credit, or the child care tax credit; and

(4) be enrolled in an education program that is focused on obtaining a career that will likely result in a livable wage.

Subd. 4. **Outcomes.** The outcome measures for the pilot project must include:

(1) improvement in the affordability, safety, and permanence of suitable housing;

(2) improvement in family functioning and stability, including in the areas of behavioral health, incarceration, involvement with the child welfare system, or equivalent indicators;

(3) improvement in education readiness and outcomes for parents and children from early childhood through high school, including reduction in absenteeism, preschool readiness scores, third grade reading competency, graduation, GPA, and standardized test improvement;

(4) improvement in attachment to the workforce of one or both parents, including enhanced job stability; wage gains; career advancement; progress in career preparation; or an equivalent combination of these or related measures; and

(5) improvement in health care access and health outcomes for parents and children.

Sec. 34. **CHILD CARE CORRECTION ORDER POSTING GUIDELINES.**

No later than November 1, 2017, the commissioner shall develop guidelines for posting public licensing data for licensed child care programs. In developing the guidelines, the commissioner shall consult with stakeholders, including licensed child care center providers, family child care providers, and county agencies.

Sec. 35. **REPEALER.**

(a) Minnesota Statutes 2016, section 13.468, is repealed.

(b) Minnesota Statutes 2016, section 119B.07, is repealed effective December 18, 2017.

ARTICLE 8

CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2016, section 245.462, subdivision 9, is amended to read:

Subd. 9. **Diagnostic assessment.** (a) "Diagnostic assessment" ~~means a written summary of the history, diagnosis, strengths, vulnerabilities, and general service needs of an adult with a mental illness using diagnostic, interview, and other relevant mental health techniques provided by a mental health professional used in developing an individual treatment plan or individual community support plan.~~ has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update.

(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment;

(4) cultural influences and their impact on the client; and

(5) mental status examination.

(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.

(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.

(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.

(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.

Sec. 2. **[245.4662] GRANT PROGRAM; MENTAL HEALTH INNOVATION.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Community partnership" means a project involving the collaboration of two or more eligible applicants.

(c) "Eligible applicant" means an eligible county, Indian tribe, mental health service provider, hospital, or community partnership. Eligible applicant does not include a state-operated direct care and treatment facility or program under chapter 246.

(d) "Intensive residential treatment services" has the meaning given in section 256B.0622, subdivision 2.

(e) "Metropolitan area" means the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Subd. 2. **Grants authorized.** The commissioner of human services shall, in consultation with stakeholders, award grants to eligible applicants to plan, establish, or operate programs to improve accessibility and quality of community-based, outpatient mental health services and reduce the number of clients admitted to regional treatment centers and community behavioral health hospitals. The commissioner shall award half of all grant funds to eligible applicants in the metropolitan area and half of all grant funds to eligible applicants outside the metropolitan area. An applicant may apply for and the commissioner may award grants for two-year periods. The commissioner may reallocate underspending among grantees within the same grant period. The mental health innovation account is established under section 246.18 for ongoing funding.

Subd. 3. **Allocation of grants.** (a) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the specific problem the grant funds will address;

(3) a letter of support from the local mental health authority;

(4) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(5) a process for documenting and evaluating results of the grant.

(b) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (c), the commissioner shall establish criteria including, but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; the proposed project's longevity and demonstrated financial sustainability after the initial grant period; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also consider other relevant factors. In evaluating applications, the commissioner may request additional information regarding a proposed project, including information on project cost. An applicant's failure

to provide the information requested disqualifies an applicant. The commissioner shall determine the number of grants awarded.

(c) Eligible applicants may receive grants under this section for purposes including, but not limited to, the following:

(1) intensive residential treatment services providing time-limited mental health services in a residential setting;

(2) the creation of stand-alone urgent care centers for mental health and psychiatric consultation services, crisis residential services, or collaboration between crisis teams and critical access hospitals;

(3) establishing new community mental health services or expanding the capacity of existing services, including supportive housing; and

(4) other innovative projects that improve options for mental health services in community settings and reduce the number of clients who remain in regional treatment centers and community behavioral health hospitals beyond when discharge is determined to be clinically appropriate.

Subd. 4. **Report to legislature.** By December 1, 2019, the commissioner of human services shall deliver a report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health issues on the outcomes of the projects funded under this section. The report shall, at a minimum, include the amount of funding awarded for each project, a description of the programs and services funded, plans for the long-term sustainability of the projects, and data on outcomes for the programs and services funded. Grantees must provide information and data requested by the commissioner to support the development of this report.

Sec. 3. Minnesota Statutes 2016, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of ~~outpatient and~~ day treatment services must complete a diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within three years preceding admission, only an adult diagnostic assessment update is necessary. An "adult diagnostic assessment update" means a written summary by a mental health professional of the adult's current mental health status and service needs and includes a face-to-face interview with the adult. If the adult's mental

health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.

Sec. 4. Minnesota Statutes 2016, section 245.4871, is amended by adding a subdivision to read:

Subd. 11a. **Diagnostic assessment.** (a) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update.

(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment;

(4) cultural influences and their impact on the client; and

(5) mental status examination.

(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.

(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.

(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family

psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.

Sec. 5. Minnesota Statutes 2016, section 245.4871, is amended by adding a subdivision to read:

Subd. 18a. **Functional assessment.** "Functional assessment" means an assessment by the case manager of the child's:

(1) mental health symptoms as presented in the child's diagnostic assessment;

(2) mental health needs as presented in the child's diagnostic assessment;

(3) use of drugs and alcohol;

(4) vocational and educational functioning;

(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the child's family;

(7) self-care and independent living capacity;

(8) medical and dental health;

(9) financial assistance needs;

(10) housing and transportation needs; and

(11) other needs and problems.

Sec. 6. Minnesota Statutes 2016, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of ~~outpatient and~~ day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.

Sec. 7. Minnesota Statutes 2016, 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;

(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 Web site 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; ~~and~~

(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 ~~(b)~~ must be designed to foster independent living in the community.

EFFECTIVE DATE. Clause (17) is effective the day following final enactment.

Sec. 8. Minnesota Statutes 2016, section 245.91, subdivision 4, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, ~~that is required to be licensed by the commissioner of human services,~~ and any agency, facility, or program that provides services or treatment for mental illness, developmental disabilities, chemical dependency, or emotional disturbance that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disabilities, chemical dependency, or emotional disturbance.

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

Sec. 9. Minnesota Statutes 2016, section 245.91, subdivision 6, is amended to read:

Subd. 6. **Serious injury.** "Serious injury" means:

(1) fractures;

(2) dislocations;

(3) evidence of internal injuries;

(4) head injuries with loss of consciousness or potential for a closed head injury or concussion without loss of consciousness requiring a medical assessment by a health care professional, whether or not further medical attention was sought;

(5) lacerations involving injuries to tendons or organs, and those for which complications are present;

(6) extensive second-degree or third-degree burns, and other burns for which complications are present;

(7) extensive second-degree or third-degree frostbite, and others for which complications are present;

(8) irreversible mobility or avulsion of teeth;

(9) injuries to the eyeball;

(10) ingestion of foreign substances and objects that are harmful;

(11) near drowning;

(12) heat exhaustion or sunstroke; ~~and~~

(13) attempted suicide; and

(14) all other injuries and incidents considered serious after an assessment by a ~~physician~~ health care professional, including but not limited to self-injurious behavior, a medication error requiring medical treatment, a suspected delay of medical treatment, a complication of a previous injury, or a complication of medical treatment for an injury.

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

Sec. 10. Minnesota Statutes 2016, section 245.94, subdivision 1, is amended to read:

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman is a health oversight agency as defined in Code of Federal Regulations, title 45, section 164.501. The ombudsman may access patient records according to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph, "records" has the meaning given in Code of Federal Regulations, title 42, section 2.53(a)(1)(i).

(c) The ombudsman may mediate or advocate on behalf of a client.

~~(c)~~ (d) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients~~, other than clients in acute care facilities who are receiving services not paid for by public funds. The ombudsman~~

~~is a health oversight agency as defined in Code of Federal Regulations, title 45, section 164.501~~.

~~(d)~~ (e) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of ~~a client~~ one or more clients who ~~is~~ may not be capable of requesting assistance have been adversely affected, the ombudsman may gather information and data about and analyze, on behalf of the client, the actions of an agency, facility, or program.

~~(e)~~ (f) The ombudsman may gather, on behalf of ~~a client~~ one or more clients, records of an agency, facility, or program, or records related to clinical drug trials from the University of Minnesota Department of Psychiatry, if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with developmental disabilities and individuals served by the Minnesota sex offender program. The ombudsman may also take photographic or videographic evidence while reviewing the actions of an agency, facility, or program, with the consent of the client. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, developmental disabilities, chemical dependency, or emotional disturbance. All data collected, created, received, or maintained by the ombudsman are governed by chapter 13 and other applicable law.

~~(f)~~ (g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

~~(g)~~ (h) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

~~(h)~~ (i) The ombudsman may attend Department of Human Services Review Board and Special Review Board proceedings; proceedings regarding the transfer of clients, as defined in section 246.50, subdivision 4, between institutions operated by the Department of Human Services; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or

proceedings and have access to private data on clients with developmental disabilities and individuals served by the Minnesota sex offender program.

~~(i)~~ (j) The ombudsman shall gather data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding services provided to clients with developmental disabilities and individuals served by the Minnesota sex offender program.

~~(j)~~ (k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(l) The Office of Ombudsman shall provide the services of the Civil Commitment Training and Resource Center.

~~(k)~~ (m) The ombudsman shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial and ensure that all protections for human subjects required by federal law and the Institutional Review Board are provided.

~~(l)~~ (n) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

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

Sec. 11. Minnesota Statutes 2016, section 245.97, subdivision 6, is amended to read:

Subd. 6. **Terms, compensation, and removal.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section ~~15.0575~~ 15.0597.

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

Sec. 12. Minnesota Statutes 2016, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related unless the residential program is a child foster care placement made by a local social services agency or a licensed child-placing agency, except as provided in subdivision 2a;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not ~~abuse chemicals or who do not have a chemical dependency~~ misuse substances or have a substance use disorder, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or chemical dependency treatment;

(9) homes providing programs for persons placed by a county or a licensed agency for legal adoption, unless the adoption is not completed within two years;

(10) programs licensed by the commissioner of corrections;

(11) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in section 315.51, whose primary purpose is to provide child care or services to school-age children;

(13) Head Start nonresidential programs which operate for less than 45 days in each calendar year;

(14) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(15) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(16) residential programs for persons with mental illness, that are located in hospitals;

(17) the religious instruction of school-age children; Sabbath or Sunday schools; or the congregate care of children by a church, congregation, or religious society during the period used by the church, congregation, or religious society for its regular worship;

(18) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(19) mental health outpatient services for adults with mental illness or children with emotional disturbance;

(20) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(21) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(22) the placement of a child by a birth parent or legal guardian in a preadoptive home for purposes of adoption as authorized by section 259.47;

(23) settings registered under chapter 144D which provide home care services licensed by the commissioner of health to fewer than seven adults;

(24) ~~chemical dependency or~~ substance ~~abuse~~ use disorder treatment activities of licensed professionals in private practice as defined in ~~Minnesota Rules, part 9530.6405, subpart 15, when the treatment activities are not paid for by the consolidated chemical dependency treatment fund~~ section 245G.01, subdivision 17;

(25) consumer-directed community support service funded under the Medicaid waiver for persons with developmental disabilities when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service;

(26) a program serving only children who are age 33 months or older, that is operated by a nonpublic school, for no more than four hours per day per child, with no more than 20 children at any one time, and that is accredited by:

(i) an accrediting agency that is formally recognized by the commissioner of education as a nonpublic school accrediting organization; or

(ii) an accrediting agency that requires background studies and that receives and investigates complaints about the services provided.

A program that asserts its exemption from licensure under item (ii) shall, upon request from the commissioner, provide the commissioner with documentation from the accrediting agency that verifies: that the accreditation is current; that the accrediting agency investigates complaints about services; and that the accrediting agency's standards require background studies on all people providing direct contact services; ~~or~~

(27) a program operated by a nonprofit organization incorporated in Minnesota or another state that serves youth in kindergarten through grade 12; provides structured, supervised youth development activities; and has learning opportunities take place before or after school, on weekends, or during the summer or other seasonal breaks in the school calendar. A program exempt under this clause is not eligible for child care assistance under chapter 119B. A program exempt under this clause must:

(i) have a director or supervisor on site who is responsible for overseeing written policies relating to the management and control of the daily activities of the program, ensuring the health and safety of program participants, and supervising staff and volunteers;

(ii) have obtained written consent from a parent or legal guardian for each youth participating in activities at the site; and

(iii) have provided written notice to a parent or legal guardian for each youth at the site that the program is not licensed or supervised by the state of Minnesota and is not eligible to receive child care assistance payments~~.~~;

(28) a county that is an eligible vendor under section 254B.05 to provide care coordination and comprehensive assessment services; or

(29) a recovery community organization that is an eligible vendor under section 254B.05 to provide peer recovery support services.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Except for the home and community-based services identified in section 245D.03, subdivision 1, nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 13. Minnesota Statutes 2016, section 245A.191, is amended to read:

245A.191 PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL DEPENDENCY CONSOLIDATED TREATMENT FUND.

(a) When a ~~chemical dependency~~ substance use disorder treatment provider licensed under this chapter, and governed by the standards of chapter 245G or Minnesota Rules, parts 2960.0430 to 2960.0490 ~~or 9530.6405 to 9530.6505~~, agrees to meet the applicable requirements under section 254B.05, subdivision 5, ~~paragraphs (b), clauses (1) to (4) and (6), (c), and (e),~~ to be eligible for enhanced funding from the chemical dependency consolidated treatment fund, the applicable requirements under section 254B.05 are also licensing requirements that may be monitored for compliance through licensing investigations and licensing inspections.

(b) Noncompliance with the requirements identified under paragraph (a) may result in:

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

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

(3) recovery of payments made for the service;

(4) disenrollment in the public payment program; or

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

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 14. **[245G.01] DEFINITIONS.**

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them.

Subd. 2. **Administration of medication.** "Administration of medication" means providing a medication to a client, and includes the following tasks, performed in the following order:

(1) checking the client's medication record;

(2) preparing the medication for administration;

(3) administering the medication to the client;

(4) documenting the administration of the medication, or the reason for not administering a medication as prescribed; and

(5) reporting information to a licensed practitioner or a nurse regarding a problem with the administration of medication or the client's refusal to take the medication, if applicable.

Subd. 3. **Adolescent.** "Adolescent" means an individual under 18 years of age.

Subd. 4. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning given in section 148F.01, subdivision 5.

Subd. 5. **Applicant.** "Applicant" has the meaning given in section 245A.02, subdivision 3.

Subd. 6. **Capacity management system.** "Capacity management system" means a database maintained by the department to compile and make information available to the public about the waiting list status and current admission capability of each opioid treatment program.

Subd. 7. **Central registry.** "Central registry" means a database maintained by the department to collect identifying information from two or more programs about an individual applying for maintenance treatment or detoxification treatment for opioid addiction to prevent an individual's concurrent enrollment in more than one program.

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.

Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 10. **Co-occurring disorders.** "Co-occurring disorders" means a diagnosis of both a substance use disorder and a mental health disorder.

Subd. 11. **Department.** "Department" means the Department of Human Services.

Subd. 12. **Direct contact.** "Direct contact" has the meaning given for "direct contact" in section 245C.02, subdivision 11.

Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive and visual communication between a client and a treatment service provider and includes services delivered in person or via telemedicine.

Subd. 14. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 15. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 16. **Licensed practitioner.** "Licensed practitioner" means an individual who is authorized to prescribe medication as defined in section 151.01, subdivision 23.

Subd. 17. **Licensed professional in private practice.** "Licensed professional in private practice" means an individual who:

(1) is licensed under chapter 148F, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

(2) practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

(3) does not affiliate with other licensed or unlicensed professionals to provide alcohol and drug counseling services. Affiliation does not include conferring with another professional or making a client referral.

Subd. 18. **Nurse.** "Nurse" means an individual licensed and currently registered to practice professional or practical nursing as defined in section 148.171, subdivisions 14 and 15.

Subd. 19. **Opioid treatment program or OTP.** "Opioid treatment program" or "OTP" means a program or practitioner engaged in opioid treatment of an individual that provides dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects of an opioid addiction. OTP includes detoxification treatment, short-term detoxification treatment, long-term detoxification treatment, maintenance treatment, comprehensive maintenance treatment, and interim maintenance treatment.

Subd. 20. **Paraprofessional.** "Paraprofessional" means an employee, agent, or independent contractor of the license holder who performs tasks to support treatment service. A paraprofessional may be referred to by a variety of titles including but not limited to technician, case aide, or counselor assistant. If currently a client of the license holder, the client cannot be a paraprofessional for the license holder.

Subd. 21. **Student intern.** "Student intern" means an individual who is authorized by a licensing board to provide services under supervision of a licensed professional.

Subd. 22. **Substance.** "Substance" means alcohol, solvents, controlled substances as defined in section 152.01, subdivision 4, and other mood-altering substances.

Subd. 23. **Substance use disorder.** "Substance use disorder" has the meaning given in the current Diagnostic and Statistical Manual of Mental Disorders.

Subd. 24. **Substance use disorder treatment.** "Substance use disorder treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned methods, including interventions or services to address a client's needs, provision of services, facilitation of services provided by other service providers, and ongoing reassessment by a qualified professional when indicated. The goal of substance use disorder treatment is to assist or support the client's efforts to recover from a substance use disorder.

Subd. 25. **Target population.** "Target population" means individuals with a substance use disorder and the specified characteristics that a license holder proposes to serve.

Subd. 26. **Telemedicine.** "Telemedicine" means the delivery of a substance use disorder treatment service while the client is at an originating site and the licensed health care provider is at a distant site as specified in section 254B.05, subdivision 5, paragraph (f).

Subd. 27. **Treatment director.** "Treatment director" means an individual who meets the qualifications specified in section 245G.11, subdivisions 1 and 3, and is designated by the license holder to be responsible for all aspects of the delivery of treatment service.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 15. **[245G.02] APPLICABILITY.**

Subdivision 1. **Applicability.** Except as provided in subdivisions 2 and 3, no person, corporation, partnership, voluntary association, controlling individual, or other organization may provide a substance use disorder treatment service to an individual with a substance use disorder unless licensed by the commissioner.

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice.

Subd. 3. **Excluded hospitals.** This chapter does not apply to substance use disorder treatment provided by a hospital licensed under chapter 62J, or under sections 144.50 to

144.56, unless the hospital accepts funds for substance use disorder treatment from the consolidated chemical dependency treatment fund under chapter 254B, medical assistance under chapter 256B, or MinnesotaCare or health care cost containment under chapter 256L, or general assistance medical care formerly codified in chapter 256D.

Subd. 4. **Applicability of Minnesota Rules, chapter 2960.** A residential adolescent substance use disorder treatment program serving an individual younger than 16 years of age must be licensed according to Minnesota Rules, chapter 2960.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 16. **[245G.03] LICENSING REQUIREMENTS.**

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in chapters 245A and 245C, sections 626.556 and 626.557, and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

Subd. 2. **Application.** Before the commissioner issues a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires.

Subd. 3. **Change in license terms.** (a) The commissioner must determine whether a new license is needed when a change in clauses (1) to (4) occurs. A license holder must notify the commissioner before a change in one of the following occurs:

(1) the Department of Health's licensure of the program;

(2) whether the license holder provides services specified in sections 245G.18 to 245G.22;

(3) location; or

(4) capacity if the license holder meets the requirements of section 245G.21.

(b) A license holder must notify the commissioner and must apply for a new license if there is a change in program ownership.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 17. **[245G.04] INITIAL SERVICES PLAN.**

(a) The license holder must complete an initial services plan on the day of service initiation. The plan must address the client's immediate health and safety concerns, identify

the needs to be addressed in the first treatment session, and make treatment suggestions for the client during the time between intake and completion of the individual treatment plan.

(b) The initial services plan must include a determination of 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. 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.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 18. **[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 service initiation for a residential program or during the initial session for all other programs. If the comprehensive assessment is not completed during the initial session, the client-centered reason for the delay must be documented in the client's file and the planned completion date. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor must review the assessment to determine compliance with this subdivision, including 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) circumstances of service initiation;

(3) previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;

(4) 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 previous withdrawal symptoms;

(5) specific problem behaviors exhibited by the client when under the influence of substances;

(6) family status, family history, including history or presence of physical or sexual abuse, level of family support, and substance misuse or substance use disorder of a family member or significant other;

(7) physical concerns or diagnoses, the severity of the concerns, and whether the concerns are being addressed by a health care professional;

(8) mental health history and psychiatric status, including symptoms, disability, current 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) ability to function appropriately in work and educational settings;

(11) ability to understand written treatment materials, including rules and the client's rights;

(12) 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 leisure time activities that are associated with substance use;

(14) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;

(15) whether the client recognizes problems related to substance use and is willing to follow treatment recommendations; and

(16) collateral information. If the assessor gathered sufficient information from the referral source or the client to apply the criteria in 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 service initiation for a residential program and within three sessions for all other programs. 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 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.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 19. **[245G.06] INDIVIDUAL TREATMENT PLAN.**

Subdivision 1. **General.** Each client must have an individual treatment plan developed by an alcohol and drug counselor within seven days of service initiation for a residential program and within three sessions for all other programs. 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. 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 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.

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 methods to address each identified need, 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.

Subd. 3. **Documentation of treatment services; treatment plan review.** (a) A review of all treatment services must be documented weekly and include a review of:

(1) care coordination activities;

(2) medical and other appointments the client attended;

(3) issues related to medications that are not documented in the medication administration record; and

(4) issues related to attendance for treatment services, including the reason for any client absence from a treatment service.

(b) A note must be entered immediately following any significant event. A significant event is an event that impacts the client's relationship with other clients, staff, the client's family, or the client's treatment plan.

(c) A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff member providing the service. The review must indicate the span of time covered by the review and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review must:

(1) indicate the date, type, and amount of each treatment service provided and the client's response to each service;

(2) address each goal in the treatment plan and whether the methods to address the goals are effective;

(3) include monitoring of any physical and mental health problems;

(4) document the participation of others;

(5) document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; and

(6) include a review and evaluation of the individual abuse prevention plan according to section 245A.65.

(d) Each entry in a client's record must be accurate, legible, signed, and dated. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.

Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a discharge summary for each client. The 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.

(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.

(c) For a client who successfully completes treatment, the summary must also include:

(1) the client's living arrangements at service termination;

(2) 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;

(3) service termination diagnosis; and

(4) the client's prognosis.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 20. **[245G.07] TREATMENT SERVICE.**

Subdivision 1. **Treatment service.** (a) A license holder must offer the following treatment services, unless clinically inappropriate and the justifying clinical rationale is documented:

(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;

(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 coordination provided by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Care 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 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.

Subd. 3. **Counselors.** A treatment service, including therapeutic recreation, must be provided by an alcohol and drug counselor according to section 245G.11, 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.

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.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 21. **[245G.08] MEDICAL SERVICES.**

Subdivision 1. **Health care services.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the applicant or license holder.

Subd. 2. **Procedures.** The applicant or license holder must have written procedures for obtaining a medical intervention for a client, that are approved in writing by a physician who is licensed under chapter 147, unless:

(1) the license holder does not provide a service under section 245G.21; and

(2) a medical intervention is referred to 911, the emergency telephone number, or the client's physician.

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 must require staff to undergo specific training in administration of naloxone.

Subd. 4. **Consultation services.** The license holder must have access to and document the availability of a licensed mental health professional to provide diagnostic assessment and treatment planning assistance.

Subd. 5. **Administration of medication and assistance with self-medication.** (a) A license holder must meet the requirements in this subdivision if a service provided includes the administration of medication.

(b) A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assisting with self-medication, must:

(1) successfully complete a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. A staff member's completion of the course must be documented in writing and placed in the staff member's personnel file;

(2) be trained according to a formalized training program that is taught by a registered nurse and offered by the license holder. The training must include the process for administration of naloxone, if naloxone is kept on site. A staff member's completion of the training must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity. A registered nurse must be employed or contracted to develop the policies and procedures for administration of medication or assisting with self-administration of medication, or both.

(c) A registered nurse must provide supervision as defined in section 148.171, subdivision 23. The registered nurse's supervision must include, at a minimum, monthly on-site supervision or more often if warranted by a client's health needs. The policies and procedures must include:

(1) a provision that a delegation of administration of medication is limited to the administration of a medication that is administered orally, topically, or as a suppository, an eye drop, an ear drop, or an inhalant;

(2) a provision that each client's file must include documentation indicating whether staff must conduct the administration of medication or the client must self-administer medication, or both;

(3) a provision that a client may carry emergency medication such as nitroglycerin as instructed by the client's physician;

(4) a provision for the client to self-administer medication when a client is scheduled to be away from the facility;

(5) a provision that if a client self-administers medication when the client is present in the facility, the client must self-administer medication under the observation of a trained staff member;

(6) a provision that when a license holder serves a client who is a parent with a child, the parent may only administer medication to the child under a staff member's supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a nurse of problems with self-administration of medication, including a client's failure to administer, refusal of a medication, adverse reaction, or error; and

(9) procedures for acceptance, documentation, and implementation of a prescription, whether written, verbal, telephonic, or electronic.

Subd. 6. **Control of drugs.** A license holder must have and implement written policies and procedures developed by a registered nurse that contain:

(1) a requirement that each drug must be stored in a locked compartment. A Schedule II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

(2) a system which accounts for all scheduled drugs each shift;

(3) a procedure for recording the client's use of medication, including the signature of the staff member who completed the administration of the medication with the time and date;

(4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

(5) a statement that only authorized personnel are permitted access to the keys to a locked compartment;

(6) a statement that no legend drug supply for one client shall be given to another client; and

(7) a procedure for monitoring the available supply of naloxone on site, replenishing the naloxone supply when needed, and destroying naloxone according to clause (4).

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 22. **[245G.09] CLIENT RECORDS.**

Subdivision 1. **Client records required.** (a) A license holder must maintain a file of current and accurate client records on the premises where the treatment service is provided or coordinated. For services provided off site, client records must be available at the program and adhere to the same clinical and administrative policies and procedures as services provided on site. The content and format of client records must be uniform and entries in each record must be signed and dated by the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure according to section 254A.09, chapter 13, and Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and title 45, parts 160 to 164.

(b) The program must have a policy and procedure that identifies how the program will track and record client attendance at treatment activities, including the date, duration, and nature of each treatment service provided to the client.

Subd. 2. **Record retention.** The client records of a discharged client must be retained by a license holder for seven years. A license holder that ceases to provide treatment service must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the client records and the name of the individual responsible for maintaining the client's records.

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record must contain documentation that the client was provided educational information according to section 245G.05, subdivision 1, paragraph (b);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) an assessment summary completed according to section 245G.05, subdivision 2;

(5) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

(6) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

(7) documentation of treatment services and treatment plan review according to section 245G.06, subdivision 3; and

(8) a summary at the time of service termination according to section 245G.06, subdivision 4.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 23. **[245G.10] STAFF REQUIREMENTS.**

Subdivision 1. **Treatment director.** A license holder must have a treatment director.

Subd. 2. **Alcohol and drug counselor supervisor.** A license holder must employ an alcohol and drug counselor supervisor who meets the requirements of section 245G.11, subdivision 4. An individual may be simultaneously employed as a treatment director, alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual meets the qualifications for each position. If an alcohol and drug counselor is simultaneously employed as an alcohol and drug counselor supervisor or treatment director, that individual must be considered a 0.5 full-time equivalent alcohol and drug counselor for staff requirements under subdivision 4.

Subd. 3. **Responsible staff member.** A treatment director must designate a staff member who, when present in the facility, is responsible for the delivery of treatment service. A license holder must have a designated staff member during all hours of operation. A license holder providing room and board and treatment at the same site must have a responsible staff member on duty 24 hours a day. The designated staff member must know and understand the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

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 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.

Subd. 5. **Medical emergency.** When a client is present, a license holder must have at least one staff member on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at least one staff member on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff member with both certifications satisfies this requirement.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 24. **[245G.11] STAFF QUALIFICATIONS.**

Subdivision 1. **General qualifications.** (a) All staff members who have direct contact must be 18 years of age or older. At the time of employment, each staff member must meet the qualifications in this subdivision. For purposes of this subdivision, "problematic substance use" means a behavior or incident listed by the license holder in the personnel policies and procedures according to section 245G.13, subdivision 1, clause (5).

(b) A treatment director, supervisor, nurse, counselor, student intern, or other professional must be free of problematic substance use for at least the two years immediately preceding employment and must sign a statement attesting to that fact.

(c) A paraprofessional, recovery peer, or any other staff member with direct contact must be free of problematic substance use for at least one year immediately preceding employment and must sign a statement attesting to that fact.

Subd. 2. **Employment; prohibition on problematic substance use.** A staff member with direct contact must be free from problematic substance use as a condition of employment, but is not required to sign additional statements. A staff member with direct contact who is not free from problematic substance use must be removed from any responsibilities that include direct contact for the time period specified in subdivision 1. The time period begins to run on the date of the last incident of problematic substance use as described in the facility's policies and procedures according to section 245G.13, subdivision 1, clause (5).

Subd. 3. **Treatment directors.** A treatment director must:

(1) have at least one year of work experience in direct service to an individual with substance use disorder or one year of work experience in the management or administration of direct service to an individual with substance use disorder;

(2) have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services; and

(3) know and understand the implications of this chapter, chapter 245A, and sections 626.556, 626.557, and 626.5572. Demonstration of the treatment director's knowledge must be documented in the personnel record.

Subd. 4. **Alcohol and drug counselor supervisors.** An alcohol and drug counselor supervisor must:

(1) meet the qualification requirements in subdivision 5;

(2) have three or more years of experience providing individual and group counseling to individuals with substance use disorder; and

(3) know and understand the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

Subd. 5. **Alcohol and drug counselor qualifications.** (a) An alcohol and drug counselor must either be licensed or exempt from licensure under chapter 148F.

(b) An individual who is exempt from licensure under chapter 148F, must meet one of the following additional requirements:

(1) completion of at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, or licensure as a registered nurse; successful completion of a minimum of 120 hours of classroom instruction in which each of the core functions listed in chapter 148F is covered; and successful completion of 440 hours of supervised experience as an alcohol and drug counselor, either as a student or a staff member;

(2) completion of at least 270 hours of drug counselor training in which each of the core functions listed in chapter 148F is covered, and successful completion of 880 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member;

(3) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc.;

(4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling education from an accredited school or educational program and 880 hours of alcohol and drug counseling practicum; or

(5) employment in a program formerly licensed under Minnesota Rules, parts 9530.5000 to 9530.6400, and successful completion of 6,000 hours of supervised work experience in a licensed program as an alcohol and drug counselor prior to January 1, 2005.

(c) An alcohol and drug counselor may not provide a treatment service that requires professional licensure unless the individual possesses the necessary license. For the purposes of enforcing this section, the commissioner has the authority to monitor a service provider's compliance with the relevant standards of the service provider's profession and may issue

licensing actions against the license holder according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's determination of noncompliance.

Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights, according to section 148F.165, and staff member responsibilities. A paraprofessional may not admit, transfer, or discharge a client but may be responsible for the delivery of treatment service according to section 245G.10, subdivision 3.

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.

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 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.

Subd. 9. **Volunteers.** A volunteer may provide treatment service when the volunteer is supervised and can be seen or heard by a staff member meeting the criteria in subdivision 4 or 5, but may not practice alcohol and drug counseling unless qualified under subdivision 5.

Subd. 10. **Student interns.** A qualified staff member must supervise and be responsible for a treatment service performed by a student intern and must review and sign each assessment, progress note, and individual treatment plan prepared by a student intern. A student intern must receive the orientation and training required in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be students or licensing candidates with time documented to be directly related to the provision of treatment services for which the staff are authorized.

Subd. 11. **Individuals with temporary permit.** An individual with a temporary permit from the Board of Behavioral Health and Therapy may provide chemical dependency treatment service according to this subdivision if they meet the requirements of either paragraph (a) or (b).

(a) An individual with a temporary permit must be supervised by a licensed alcohol and drug counselor assigned by the license holder. The supervising licensed alcohol and drug counselor must document the amount and type of supervision provided at least on a weekly basis. The supervision must relate to the clinical practice.

(b) An individual with a temporary permit must be supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of section 148F.04, subdivision 4.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 25. **[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;

(11) the methods used to achieve desired client outcomes;

(12) the hours of operation; and

(13) the target population served.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 26. **[245G.13] PROVIDER PERSONNEL POLICIES.**

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 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.

Subd. 2. **Staff development.** (a) A license holder must ensure that each staff member has the training described in this subdivision.

(b) Each staff member must be trained every two years in:

(1) client confidentiality rules and regulations and client ethical boundaries; and

(2) emergency procedures and client rights as specified in sections 144.651, 148F.165, and 253B.03.

(c) Annually each staff member with direct contact must be trained on mandatory reporting as specified in sections 245A.65, 626.556, 626.5561, 626.557, and 626.5572,

including specific training covering the license holder's policies for obtaining a release of client information.

(d) Upon employment and annually thereafter, each staff member with direct contact must receive training on HIV minimum standards according to section 245A.19.

(e) A treatment director, supervisor, nurse, or counselor must have a minimum of 12 hours of training in co-occurring disorders that includes competencies related to philosophy, trauma-informed care, screening, assessment, diagnosis and person-centered treatment planning, documentation, programming, medication, collaboration, mental health consultation, and discharge planning. A new staff member who has not obtained the training must complete the training within six months of employment. A staff member may request, and the license holder may grant, credit for relevant training obtained before employment, which must be documented in the staff member's personnel file.

Subd. 3. **Personnel files.** The license holder must maintain a separate personnel file for each staff member. At a minimum, the personnel file must conform to the requirements of this chapter. A personnel file must contain the following:

(1) a completed application for employment signed by the staff member and containing the staff member's qualifications for employment;

(2) documentation related to the staff member's background study data, according to chapter 245C;

(3) for a staff member who provides psychotherapy services, employer names and addresses for the past five years for which the staff member provided psychotherapy services, and documentation of an inquiry required by sections 604.20 to 604.205 made to the staff member's former employer regarding substantiated sexual contact with a client;

(4) documentation that the staff member completed orientation and training;

(5) documentation that the staff member meets the requirements in section 245G.11;

(6) documentation demonstrating the staff member's compliance with section 245G.08, subdivision 3, for a staff member who conducts administration of medication; and

(7) documentation demonstrating the staff member's compliance with section 245G.18, subdivision 2, for a staff member that treats an adolescent client.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 27. **[245G.14] SERVICE INITIATION AND TERMINATION POLICIES.**

Subdivision 1. **Service initiation policy.** A license holder must have a written service initiation policy containing service initiation preferences that comply with this section and Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria. The license holder must not initiate services for an individual who does not meet the service initiation criteria. The service initiation criteria must be either posted in the area of the facility where services for a client are initiated, or given to each interested person upon request. Titles of each staff member authorized to initiate services for a client must be listed in the services initiation and termination policies.

Subd. 2. **License holder responsibilities.** (a) The license holder must have and comply with a written protocol for (1) assisting a client in need of care not provided by the license holder, and (2) a client who poses a substantial likelihood of harm to the client or others, if the behavior is beyond the behavior management capabilities of the staff members.

(b) A service termination and denial of service initiation that poses an immediate threat to the health of any individual or requires immediate medical intervention must be referred to a medical facility capable of admitting the client.

(c) A service termination policy and a denial of service initiation that involves the commission of a crime against a license holder's staff member or on a license holder's premises, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164, must be reported to a law enforcement agency with jurisdiction.

Subd. 3. **Service termination policies.** A license holder must have a written policy specifying the conditions when a client must be terminated from service. The service termination policy must include:

(1) procedures for a client whose services were terminated under subdivision 2;

(2) a description of client behavior that constitutes reason for a staff-requested service termination and a process for providing this information to a client;

(3) a requirement that before discharging a client from a residential setting, for not reaching treatment plan goals, the license holder must confer with other interested persons to review the issues involved in the decision. The documentation requirements for a staff-requested service termination must describe why the decision to discharge is warranted, the reasons for the discharge, and the alternatives considered or attempted before discharging the client;

(4) procedures consistent with section 253B.16, subdivision 2, that staff members must follow when a client admitted under chapter 253B is to have services terminated;

(5) procedures a staff member must follow when a client leaves against staff or medical advice and when the client may be dangerous to the client or others, including a policy that requires a staff member to assist the client with assessing needs of care or other resources;

(6) procedures for communicating staff-approved service termination criteria to a client, including the expectations in the client's individual treatment plan according to section 245G.06; and

(7) titles of each staff member authorized to terminate a client's service must be listed in the service initiation and service termination policies.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 28. **[245G.15] CLIENT RIGHTS PROTECTION.**

Subdivision 1. **Explanation.** A client has the rights identified in sections 144.651, 148F.165, 253B.03, and 254B.02, subdivision 2, as applicable. The license holder must give each client at 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.

Subd. 2. **Grievance procedure.** At 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.

Subd. 3. **Photographs of client.** (a) A photograph, video, or motion picture of a client taken in the provision of treatment service is considered client records. A photograph for identification and a recording by video or audio technology to enhance either therapy or staff member supervision may be required of a client, but may only be available for use as

communications within a program. A client must be informed when the client's actions are being recorded by camera or other technology, and the client must have the right to refuse any recording or photography, except as authorized by this subdivision.

(b) A license holder must have a written policy regarding the use of any personal electronic device that can record, transmit, or make images of another client. A license holder must inform each client of this policy and the client's right to refuse being photographed or recorded.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 29. **[245G.16] BEHAVIORAL EMERGENCY PROCEDURES.**

(a) A license holder or applicant must have written behavioral emergency procedures that staff must follow when responding to a client who exhibits behavior that is threatening to the safety of the client or others. Programs must incorporate person-centered planning and trauma-informed care in the program's behavioral emergency procedure policies. The procedures must include:

(1) a plan designed to prevent a client from hurting themselves or others;

(2) contact information for emergency resources that staff must consult when a client's behavior cannot be controlled by the behavioral emergency procedures;

(3) types of procedures that may be used;

(4) circumstances under which behavioral emergency procedures may be used; and

(5) staff members authorized to implement behavioral emergency procedures.

(b) Behavioral emergency procedures must not be used to enforce facility rules or for the convenience of staff. Behavioral emergency procedures must not be part of any client's treatment plan, or used at any time for any reason except in response to specific current behavior that threatens the safety of the client or others. Behavioral emergency procedures may not include the use of seclusion or restraint.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 30. **[245G.17] EVALUATION.**

A license holder must participate in the drug and alcohol abuse normative evaluation system by submitting information about each client to the commissioner in a manner prescribed by the commissioner. A license holder must submit additional information

requested by the commissioner that is necessary to meet statutory or federal funding requirements.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 31. **[245G.18] LICENSE HOLDERS SERVING ADOLESCENTS.**

Subdivision 1. **License.** A residential treatment program that serves an adolescent younger than 16 years of age must be licensed as a residential program for a child in out-of-home placement by the department unless the license holder is exempt under section 245A.03, subdivision 2.

Subd. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in section 245G.11, subdivisions 1 and 5, an alcohol and drug counselor providing treatment service to an adolescent must have:

(1) an additional 30 hours of classroom instruction or one three-credit semester college course in adolescent development. This training need only be completed one time; and

(2) at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.

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.

Subd. 4. **Academic program requirements.** A client who is required to attend school must be enrolled and attending an educational program that was approved by the Department of Education.

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 use; and

(3) a plan that addresses family involvement in the adolescent's treatment.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 32. **[245G.19] LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.**

Subdivision 1. **Health license requirements.** In addition to the requirements of sections 245G.01 to 245G.17, a license holder that offers supervision of a child of a client is subject to the requirements of this section. A license holder providing room and board for a client and the client's child must have an appropriate facility license from the Department of Health.

Subd. 2. **Supervision of a child.** "Supervision of a child" means a caregiver is within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can intervene to protect the child's health and safety. For a school-age child it means a caregiver is available to help and care for the child to protect the child's health and safety.

Subd. 3. **Policy and schedule required.** A license holder must meet the following requirements:

(1) have a policy and schedule delineating the times and circumstances when the license holder is responsible for supervision of a child in the program and when the child's parents are responsible for supervision of a child. The policy must explain how the program will communicate its policy about supervision of a child responsibility to the parent; and

(2) have written procedures addressing the actions a staff member must take if a child is neglected or abused, including while the child is under the supervision of the child's parent.

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) 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 January 1, 2018.

Sec. 33. **[245G.20] LICENSE HOLDERS SERVING PERSONS WITH CO-OCCURRING DISORDERS.**

A license holder specializing in the treatment of a person with co-occurring disorders must:

(1) demonstrate that staff levels are appropriate for treating a client with a co-occurring disorder, and that there are adequate staff members with mental health training;

(2) have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medication;

(3) have a mental health professional available for staff member supervision and consultation;

(4) determine group size, structure, and content considering the special needs of a client with a co-occurring disorder;

(5) have documentation of active interventions to stabilize mental health symptoms present in the individual treatment plans and progress notes;

(6) have continuing documentation of collaboration with continuing care mental health providers, and involvement of the providers in treatment planning meetings;

(7) have available program materials adapted to a client with a mental health problem;

(8) have policies that provide flexibility for a client who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping a client successfully complete treatment; and

(9) have individual psychotherapy and case management available during treatment service.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 34. **[245G.21] REQUIREMENTS FOR LICENSED RESIDENTIAL TREATMENT.**

Subdivision 1. **Applicability.** A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program according to section 245A.02, subdivision 14, and is subject to this section.

Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours, including both day and evening times. A client's right to receive visitors other than a personal

physician, religious adviser, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided the limitation and the reasons for the limitation are documented in the client's file. A client must be allowed to receive visits at all reasonable times from the client's personal physician, religious adviser, county case manager, parole or probation officer, and attorney.

Subd. 3. **Client property management.** A license holder who provides room and board and treatment services to a client in the same facility, and any license holder that accepts client property must meet the requirements for handling client funds and property in section 245A.04, subdivision 13. License holders:

(1) may establish policies regarding the use of personal property to ensure that treatment activities and the rights of other clients are not infringed upon;

(2) may take temporary custody of a client's property for violation of a facility policy;

(3) must retain the client's property for a minimum of seven days after the client's service termination if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and

(4) must return all property held in trust to the client at service termination regardless of the client's service termination status, except that:

(i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section 609.5316, must be given to the custody of a local law enforcement agency. If giving the property to the custody of a local law enforcement agency violates Code of Federal Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug paraphernalia, or drug container must be destroyed by a staff member designated by the program director; and

(ii) a weapon, explosive, and other property that can cause serious harm to the client or others must be given to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the client's right to reclaim any lawful property transferred; and

(iii) a medication that was determined by a physician to be harmful after examining the client must be destroyed, except when the client's personal physician approves the medication for continued use.

Subd. 4. **Health facility license.** A license holder who provides room and board and treatment services in the same facility must have the appropriate license from the Department of Health.

Subd. 5. **Facility abuse prevention plan.** A license holder must establish and enforce an ongoing facility abuse prevention plan consistent with sections 245A.65 and 626.557, subdivision 14.

Subd. 6. **Individual abuse prevention plan.** A license holder must prepare an individual abuse prevention plan for each client as specified under sections 245A.65, subdivision 2, and 626.557, subdivision 14.

Subd. 7. **Health services.** A license holder must have written procedures for assessing and monitoring a client's health, including a standardized data collection tool for collecting health-related information about each client. The policies and procedures must be approved and signed by a registered nurse.

Subd. 8. **Administration of medication.** A license holder must meet the administration of medications requirements of section 245G.08, subdivision 5, if services include medication administration.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 35. **[245G.22] OPIOID TREATMENT PROGRAMS.**

Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed under this chapter must also 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.

(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.

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 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 authorized program physicians and health care professionals functioning under the medical director's direct supervision.

(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) "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.

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 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 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 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.

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. The meeting must occur before the administration or dispensing of the increased medication dose.

Subd. 5. **Drug testing.** Each client enrolled in the program must receive a minimum of eight random drug abuse tests per 12 months of treatment. Drug abuse tests must be

reasonably disbursed over the 12-month period. A license holder may elect to conduct more drug abuse tests.

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:

(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 with authority to prescribe must consider the criteria in this paragraph. The criteria in this paragraph must also be considered when determining whether dispensing medication for a client's unsupervised use is appropriate to 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.

Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a physician with authority to prescribe 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.

(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.

Subd. 8. **Restriction exceptions.** When a license holder has reason to accelerate the number of unsupervised use doses of methadone hydrochloride, the license holder must comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the criteria for unsupervised use and must use the exception process provided by the federal Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the purposes of enforcement of this subdivision, the commissioner has the authority to monitor a program for compliance with federal regulations and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 9. **Guest dose.** To receive a guest dose, the client must be enrolled in an opioid treatment program elsewhere in the state or country and be receiving the medication on a temporary basis because the client is not able to receive the medication at the program in which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and must not be for the convenience or benefit of either program. A guest dose may also occur when the client's primary clinic is not open and the client is not receiving unsupervised use doses.

Subd. 10. **Capacity management and waiting list system compliance.** An opioid treatment program must notify the department within seven days of the program reaching both 90 and 100 percent of the program's capacity to care for clients. Each week, the program must report its capacity, currently enrolled dosing clients, and any waiting list. A program reporting 90 percent of capacity must also notify the department when the program's census increases or decreases from the 90 percent level.

Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system. If the person seeking admission cannot be admitted within 14 days of the date of application, each person seeking admission must be placed on the waiting list, unless the person seeking admission is assessed by the program and found ineligible for admission according to this chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each person seeking treatment while awaiting admission. A person seeking admission on a waiting list who receives no services under section 245G.07, subdivision 1, must not be considered a client as defined in section 245G.01, subdivision 9.

Subd. 12. **Client referral.** An opioid treatment program must consult the capacity management system to ensure that a person on a waiting list is admitted at the earliest time to a program providing appropriate treatment within a reasonable geographic area. If the client was referred through a public payment system and if the program is not able to serve the client within 14 days of the date of application for admission, the program must contact and inform the referring agency of any available treatment capacity listed in the state capacity management system.

Subd. 13. **Outreach.** An opioid treatment program must carry out activities to encourage an individual in need of treatment to undergo treatment. The program's outreach model must:

(1) select, train, and supervise outreach workers;

(2) contact, communicate, and follow up with individuals with high-risk substance misuse, individuals with high-risk substance misuse associates, and neighborhood residents within the constraints of federal and state confidentiality requirements;

(3) promote awareness among individuals who engage in substance misuse by injection about the relationship between injecting substances and communicable diseases such as HIV; and

(4) recommend steps to prevent HIV transmission.

Subd. 14. **Central registry.** (a) A license holder must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The license holder must submit data concerning medication used for the treatment of opioid use disorder. The data must be submitted in a method determined by the commissioner and the original information must be kept in the client's record. The information must be submitted for each client at admission and discharge. The program must document the date the information was submitted. The client's failure to provide the information shall prohibit participation in an opioid treatment program. The information submitted must include the client's:

(1) full name and all aliases;

(2) date of admission;

(3) date of birth;

(4) Social Security number or Alien Registration Number, if any;

(5) current or previous enrollment status in another opioid treatment program;

(6) government-issued photo identification card number; and

(7) driver's license number, if any.

(b) The requirements in paragraph (a) are effective upon the commissioner's implementation of changes to the drug and alcohol abuse normative evaluation system or development of an electronic system by which to submit the data.

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, 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 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;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes must be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress 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.

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 a medication used for the treatment of substance use disorder is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient 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;

(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 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 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 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.

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 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).

(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.

(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.

Subd. 18. **Quality improvement plan.** The license holder must develop and maintain a quality improvement plan that:

(1) includes evaluation of the services provided to clients to identify issues that may improve service delivery and client outcomes;

(2) includes goals for the program to accomplish based on the evaluation;

(3) is reviewed annually by the management of the program to determine whether the goals were met and, if not, whether additional action is required;

(4) is updated at least annually to include new or continued goals based on an updated evaluation of services; and

(5) identifies two specific goal areas, in addition to others identified by the program, including:

(i) a goal concerning oversight and monitoring of the premises around and near the exterior of the program to reduce the possibility of medication used for the treatment of opioid use disorder being inappropriately used by a client, including but not limited to the sale or transfer of the medication to others; and

(ii) a goal concerning community outreach, including but not limited to communications with local law enforcement and county human services agencies, to increase coordination of services and identification of areas of concern to be addressed in the plan.

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 and changes in medications used for the treatment of opioid use disorder ordered for the client.

Subd. 20. **Duty to report suspected drug diversion.** (a) To the fullest extent permitted under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to law enforcement any credible evidence that the program or its personnel knows, or reasonably should know, that is directly related to a diversion crime on the premises of the program, or a threat to commit a diversion crime.

(b) "Diversion crime," for the purposes of this section, means diverting, attempting to divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02, on the program's premises.

(c) The program must document the program's compliance with the requirement in paragraph (a) in either a client's record or an incident report. A program's failure to comply with paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 36. Minnesota Statutes 2016, section 246.18, subdivision 4, is amended to read:

Subd. 4. **Collections deposited in the general fund.** Except as provided in subdivisions 5, 6, and 7, all receipts from collection efforts for the regional treatment centers, state nursing homes~~,~~ and other state facilities as defined in section 246.50, subdivision 3, must be deposited in the general fund. From that amount, receipts from collection efforts for the Anoka-Metro Regional Treatment Center and community behavioral health hospitals must be deposited in accordance with subdivision 4a. The commissioner shall ensure that the departmental financial reporting systems and internal accounting procedures comply with federal standards

for reimbursement for program and administrative expenditures and fulfill the purpose of this ~~paragraph~~ subdivision.

Sec. 37. Minnesota Statutes 2016, section 246.18, is amended by adding a subdivision to read:

Subd. 4a. **Mental health innovation account.** The mental health innovation account is established in the special revenue fund. Beginning in fiscal year 2018, $1,000,000 of the revenue generated by collection efforts from the Anoka-Metro Regional Treatment Center and community behavioral health hospitals under section 246.54 must annually be deposited into the mental health innovation account. Money deposited in the mental health innovation account is appropriated to the commissioner of human services for the mental health innovation grant program under section 245.4662.

Sec. 38. Minnesota Statutes 2016, section 254A.01, is amended to read:

254A.01 PUBLIC POLICY.

It is hereby declared to be the public policy of this state that scientific evidence shows that addiction to alcohol or other drugs is a chronic brain disorder with potential for recurrence, and as with many other chronic conditions, people with substance use disorders can be effectively treated and can enter recovery. The interests of society are best served by reducing the stigma of substance use disorder and providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services that span intensity levels and are not restricted to a particular point in time. Further, it is declared that treatment under these services shall be voluntary when possible: treatment shall not be denied on the basis of prior treatment; treatment shall be based on an individual treatment plan for each person undergoing treatment; treatment shall include a continuum of services available for a person leaving a program of treatment; treatment shall include all family members at the earliest possible phase of the treatment process.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 39. Minnesota Statutes 2016, section 254A.02, subdivision 2, is amended to read:

Subd. 2. **Approved treatment program.** "Approved treatment program" means care and treatment services provided by any individual, organization or association to ~~drug dependent~~ persons with a substance use disorder, which meets the standards established by the commissioner of human services.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 40. Minnesota Statutes 2016, section 254A.02, subdivision 3, is amended to read:

Subd. 3. **Comprehensive program.** "Comprehensive program" means the range of services which are to be made available for the purpose of prevention, care and treatment of ~~alcohol and drug abuse~~ substance misuse and substance use disorder.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 41. Minnesota Statutes 2016, section 254A.02, subdivision 5, is amended to read:

Subd. 5. **Drug dependent person.** "Drug dependent person" means any ~~inebriate person or any~~ person incapable of self-management or management of personal affairs or unable to function physically or mentally in an effective manner because of the abuse of a drug, including alcohol.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 42. Minnesota Statutes 2016, section 254A.02, subdivision 6, is amended to read:

Subd. 6. **Facility.** "Facility" means any treatment facility administered under an approved treatment program ~~established under Laws 1973, chapter 572~~.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 43. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision to read:

Subd. 6a. **Substance misuse.** "Substance misuse" means the use of any psychoactive or mood-altering substance, without compelling medical reason, in a manner that results in mental, emotional, or physical impairment and causes socially dysfunctional or socially disordering behavior and that results in psychological dependence or physiological addiction as a function of continued use. Substance misuse has the same meaning as drug abuse or abuse of drugs.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 44. Minnesota Statutes 2016, section 254A.02, subdivision 8, is amended to read:

Subd. 8. **Other drugs.** "Other drugs" means any psychoactive ~~chemical~~ substance other than alcohol.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 45. Minnesota Statutes 2016, section 254A.02, subdivision 10, is amended to read:

Subd. 10. **State authority.** "State authority" is a division established within the Department of Human Services for the purpose of relating the authority of state government in the area of ~~alcohol and drug abuse~~ substance misuse and substance use disorder to the ~~alcohol and drug abuse~~ substance misuse and substance use disorder-related activities within the state.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 46. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision to read:

Subd. 10a. **Substance use disorder.** "Substance use disorder" has the meaning given in the current Diagnostic and Statistical Manual of Mental Disorders.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 47. Minnesota Statutes 2016, section 254A.03, is amended to read:

254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.

Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an Alcohol and Other Drug Abuse Section in the Department of Human Services. This section shall be headed by a director. The commissioner may place the director's position in the unclassified service if the position meets the criteria established in section 43A.08, subdivision 1a. The section shall:

(1) conduct and foster basic research relating to the cause, prevention and methods of diagnosis, treatment and rehabilitation of ~~alcoholic and other drug dependent~~ persons with substance misuse and substance use disorder;

(2) coordinate and review all activities and programs of all the various state departments as they relate to ~~alcohol and other drug dependency and abuse~~ problems associated with substance misuse and substance use disorder;

(3) develop, demonstrate, and disseminate new methods and techniques for ~~the~~ prevention, early intervention, treatment and ~~rehabilitation of alcohol and other drug abuse and dependency problems~~ recovery support for substance misuse and substance use disorder;

(4) gather facts and information about ~~alcoholism and other drug dependency and abuse~~ substance misuse and substance use disorder, and about the efficiency and effectiveness of prevention, treatment, and ~~rehabilitation~~ recovery support services from all comprehensive

programs, including programs approved or licensed by the commissioner of human services or the commissioner of health or accredited by the Joint Commission on Accreditation of Hospitals. The state authority is authorized to require information from comprehensive programs which is reasonable and necessary to fulfill these duties. When required information has been previously furnished to a state or local governmental agency, the state authority shall collect the information from the governmental agency. The state authority shall disseminate facts and summary information about ~~alcohol and other drug abuse dependency~~ problems associated with substance misuse and substance use disorder to public and private agencies, local governments, local and regional planning agencies, and the courts for guidance to and assistance in prevention, treatment and ~~rehabilitation~~ recovery support;

(5) inform and educate the general public on ~~alcohol and other drug dependency and abuse problems~~ substance misuse and substance use disorder;

(6) serve as the state authority concerning ~~alcohol and other drug dependency and abuse~~ substance misuse and substance use disorder by monitoring the conduct of diagnosis and referral services, research and comprehensive programs. The state authority shall submit a biennial report to the governor and the legislature containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost;

(7) establish a state plan which shall set forth goals and priorities for a comprehensive ~~alcohol and other drug dependency and abuse program~~ continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies operating ~~alcohol and other drug abuse or dependency~~ substance misuse or substance use disorder programs or administering state or federal funds for such programs shall annually set their program goals and priorities in accordance with the state plan. Each state agency shall annually submit its plans and budgets to the state authority for review. The state authority shall certify whether proposed services comply with the comprehensive state plan and advise each state agency of review findings;

(8) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using federal funds, and state funds as authorized to pay for costs of state administration, including evaluation, statewide programs and services, research and demonstration projects, and American Indian programs;

(9) receive and administer ~~monies~~ money available for ~~alcohol and drug abuse~~ substance misuse and substance use disorder programs under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9;

(10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter 572, and any grant of money, services, or property from the federal government, the state, any political subdivision thereof, or any private source;

(11) with respect to ~~alcohol and other drug abuse~~ substance misuse and substance use disorder programs serving the American Indian community, establish guidelines for the employment of personnel with considerable practical experience in ~~alcohol and other drug abuse problems~~ substance misuse and substance use disorder, and understanding of social and cultural problems related to ~~alcohol and other drug abuse~~ substance misuse and substance use disorder, in the American Indian community.

Subd. 2. **American Indian programs.** There is hereby created a section of American Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human Services, to be headed by a special assistant for American Indian programs on ~~alcoholism and drug abuse~~ substance misuse and substance use disorder and two assistants to that position. The section shall be staffed with all personnel necessary to fully administer programming for ~~alcohol and drug abuse~~ substance misuse and substance use disorder services for American Indians in the state. The special assistant position shall be filled by a person with considerable practical experience in and understanding of ~~alcohol and other drug abuse problems~~ substance misuse and substance use disorder in the American Indian community, who shall be responsible to the director of the Alcohol and Drug Abuse Section created in subdivision 1 and shall be in the unclassified service. The special assistant shall meet and consult with the American Indian Advisory Council as described in section 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report on the status of ~~alcohol and other drug abuse~~ substance misuse and substance use disorder among American Indians in the state of Minnesota. The special assistant with the approval of the director shall:

(1) administer funds appropriated for American Indian groups, organizations and reservations within the state for American Indian ~~alcoholism and drug abuse~~ substance misuse and substance use disorder programs;

(2) establish policies and procedures for such American Indian programs with the assistance of the American Indian Advisory Board; and

(3) hire and supervise staff to assist in the administration of the American Indian program section within the Alcohol and Drug Abuse Section of the Department of Human Services.

Subd. 3. **Rules for ~~chemical dependency~~ 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 ~~alcohol or other drug dependency and abuse problems.~~ 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.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 48. Minnesota Statutes 2016, section 254A.035, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** There is created an American Indian Advisory Council to assist the state authority on ~~alcohol and drug abuse~~ substance misuse and substance use disorder in proposal review and formulating policies and procedures relating to ~~chemical dependency and the abuse of alcohol and other drugs~~ substance misuse and substance use disorder by American Indians.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 49. Minnesota Statutes 2016, section 254A.04, is amended to read:

254A.04 CITIZENS ADVISORY COUNCIL.

There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise the Department of Human Services concerning the problems of ~~alcohol and other drug dependency and abuse~~ substance misuse and substance use disorder, composed of ten members. Five members shall be individuals whose interests or training are in the field of ~~alcohol dependency~~ alcohol-specific substance use disorder and ~~abuse~~ alcohol misuse; and five members whose interests or training are in the field of ~~dependency~~ substance use disorder and ~~abuse of drugs~~ misuse of substances other than alcohol. The terms, compensation and removal of members shall be as provided in section 15.059. The council expires June

30, 2018. The commissioner of human services shall appoint members whose terms end in even-numbered years. The commissioner of health shall appoint members whose terms end in odd-numbered years.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 50. Minnesota Statutes 2016, section 254A.08, is amended to read:

254A.08 DETOXIFICATION CENTERS.

Subdivision 1. **Detoxification services.** Every county board shall provide detoxification services for ~~drug dependent persons~~ any person incapable of self-management or management of personal affairs or unable to function physically or mentally in an effective manner because of the use of a drug, including alcohol. The board may utilize existing treatment programs and other agencies to meet this responsibility.

Subd. 2. **Program requirements.** For the purpose of this section, a detoxification program means a social rehabilitation program licensed by the Department of Human Services under chapter 245A, and governed by the standards of Minnesota Rules, parts 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and treatment by detoxifying and evaluating the person and providing entrance into a comprehensive program. Evaluation of the person shall include verification by a professional, after preliminary examination, that the person is intoxicated or has symptoms of ~~chemical dependency~~ substance misuse or substance use disorder and appears to be in imminent danger of harming self or others. A detoxification program shall have available the services of a licensed physician for medical emergencies and routine medical surveillance. A detoxification program licensed by the Department of Human Services to serve both adults and minors at the same site must provide for separate sleeping areas for adults and minors.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 51. Minnesota Statutes 2016, section 254A.09, is amended to read:

254A.09 CONFIDENTIALITY OF RECORDS.

The Department of Human Services shall assure confidentiality to individuals who are the subject of research by the state authority or are recipients of ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment, or treatment from a licensed or approved program. The commissioner shall withhold from all persons not connected with the conduct of the research the names or other identifying characteristics of a subject of research unless the individual gives written permission that information

relative to treatment and recovery may be released. Persons authorized to protect the privacy of subjects of research may not be compelled in any federal, state or local, civil, criminal, administrative or other proceeding to identify or disclose other confidential information about the individuals. Identifying information and other confidential information related to ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment, treatment, or aftercare services may be ordered to be released by the court for the purpose of civil or criminal investigations or proceedings if, after review of the records considered for disclosure, the court determines that the information is relevant to the purpose for which disclosure is requested. The court shall order disclosure of only that information which is determined relevant. In determining whether to compel disclosure, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the treatment relationship in the program affected and in other programs similarly situated, and the actual or potential harm to the ability of programs to attract and retain patients if disclosure occurs. This section does not exempt any person from the reporting obligations under section 626.556, nor limit the use of information reported in any proceeding arising out of the abuse or neglect of a child. Identifying information and other confidential information related to ~~alcohol or drug abuse information~~ substance misuse or substance use disorder, assessment, treatment, or aftercare services may be ordered to be released by the court for the purpose of civil or criminal investigations or proceedings. No information may be released pursuant to this section that would not be released pursuant to section 595.02, subdivision 2.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 52. Minnesota Statutes 2016, section 254A.19, subdivision 3, is amended to read:

Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b) ~~or~~, (c), or (d), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.

(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:

(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference;

(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider; or

(3) the county social service agency has an existing relationship with an assessor or service provider and elects to enter into a contract with that assessor to provide both assessment and treatment under circumstances specified in the county's contract, provided the county retains responsibility for making placement decisions.

(c) The county may contract with a hospital to conduct chemical assessments if the requirements in subdivision 1a are met.

An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.

(d) An eligible vendor under section 254B.05 conducting a comprehensive assessment for an individual seeking treatment shall approve the nature, intensity level, and duration of treatment service if a need for services is indicated, but the individual assessed can access any enrolled provider that is licensed to provide the level of service authorized, including the provider or program that completed the assessment. If an individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 53. Minnesota Statutes 2016, section 254B.01, subdivision 3, is amended to read:

Subd. 3. **~~Chemical dependency~~ Substance use disorder treatment services.** "~~Chemical dependency~~ Substance use disorder treatment services" means a planned program of care for the treatment of ~~chemical dependency~~ substance misuse or ~~chemical abuse~~ substance use disorder to minimize or prevent further ~~chemical abuse~~ substance misuse by the person. Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services that are not part of a program of care licensable as a residential or nonresidential ~~chemical dependency~~ substance use disorder treatment program are not ~~chemical dependency~~ substance use disorder services for purposes of this section. For pregnant and postpartum women, ~~chemical dependency~~ substance use disorder services include halfway house services, aftercare services, psychological services, and case management.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 54. Minnesota Statutes 2016, section 254B.01, is amended by adding a subdivision to read:

Subd. 8. **Recovery community organization.** "Recovery community organization" means an independent organization led and governed by representatives of local communities of recovery. A recovery community organization mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Recovery community organizations provide peer-based recovery support activities such as training of recovery peers. Recovery community organizations provide mentorship and ongoing support to individuals dealing with a substance use disorder and connect them with the resources that can support each person's recovery. A recovery community organization also promotes a recovery-focused orientation in community education and outreach programming, and organize recovery-focused policy advocacy activities to foster healthy communities and reduce the stigma of substance use disorder.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 55. Minnesota Statutes 2016, 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. ~~Except for chemical dependency transitional rehabilitation programs,~~ 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 section 254B.05, 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 January 1, 2018.

Sec. 56. Minnesota Statutes 2016, 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, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 57. Minnesota Statutes 2016, section 254B.04, subdivision 2b, is amended to read:

Subd. 2b. **Eligibility for placement in opioid treatment programs.** ~~(a) Notwithstanding provisions of Minnesota Rules, part 9530.6622, subpart 5, related to a placement authority's requirement to authorize services or service coordination in a program that complies with Minnesota Rules, part 9530.6500, or Code of Federal Regulations, title 42, part 8, and after taking into account an individual's preference for placement in an opioid treatment program, a placement authority may, but is not required to, authorize services or service coordination or otherwise place an individual in an opioid treatment program. Prior to making a~~

~~determination of placement for an individual, the placing authority must consult with the current treatment provider, if any.~~

~~(b)~~ Prior to placement of an individual who is determined by the assessor to require treatment for opioid addiction, the assessor must provide educational information concerning treatment options for opioid addiction, including the use of a medication for the use of opioid addiction. The commissioner shall develop educational materials supported by research and updated periodically that must be used by assessors to comply with this requirement.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 58. Minnesota Statutes 2016, 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 ~~chemical dependency primary~~ 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, 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 ~~chemical dependency~~

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.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 59. Minnesota Statutes 2016, 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 ~~Minnesota Rules, part 9530.6450, subpart 1, item A~~ section 245G.11, subdivision 1, paragraph (a);

(9) has emergency behavioral procedures that meet the requirements of ~~Minnesota Rules, part 9530.6475~~ section 245G.16;

(10) meets the requirements of ~~Minnesota Rules, part 9530.6435, subparts 3 and 4, items A and B~~ 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 ~~Minnesota Rules, part 9530.6470, subpart 2~~ 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).

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 60. Minnesota Statutes 2016, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for ~~chemical dependency~~ substance use disorder services and service enhancements funded under this chapter.

(b) Eligible ~~chemical dependency~~ substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480~~ 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);

(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), clause (5);

(5) on July 1, 2018, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

~~(2)~~ (6) medication-assisted therapy services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500~~ section 245G.07, subdivision 1, or applicable tribal license;

~~(3)~~ (7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause ~~(2)~~ (6) and provide nine hours of clinical services each week;

~~(4)~~ (8) high, medium, and low intensity residential treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ sections 245G.01 to 245G.17 and 245G.22 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

~~(5)~~ (9) hospital-based treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480,~~ sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(6)~~ (10) adolescent treatment programs that are licensed as outpatient treatment programs according to ~~Minnesota Rules, parts 9530.6405 to 9530.6485,~~ 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;

~~(7)~~ (11) high-intensity residential treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ 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

~~(8)~~ (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 ~~Minnesota Rules, part 9530.6490, subpart 4~~ 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 ~~Minnesota Rules, part 9530.6495~~ 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 ~~Minnesota Rules, part 9530.6490~~ 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.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 61. Minnesota Statutes 2016, section 254B.051, is amended to read:

254B.051 SUBSTANCE ~~ABUSE~~ USE DISORDER TREATMENT EFFECTIVENESS.

In addition to the substance ~~abuse~~ use disorder treatment program performance outcome measures that the commissioner of human services collects annually from treatment providers, the commissioner shall request additional data from programs that receive appropriations from the consolidated chemical dependency treatment fund. This data shall include number of client readmissions six months after release from inpatient treatment, and the cost of treatment per person for each program receiving consolidated chemical dependency treatment funds. The commissioner may post this data on the department Web site.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 62. Minnesota Statutes 2016, section 254B.07, is amended to read:

254B.07 THIRD-PARTY LIABILITY.

The state agency provision and payment of, or liability for, ~~chemical dependency~~ substance use disorder medical care is the same as in section 256B.042.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 63. Minnesota Statutes 2016, section 254B.08, is amended to read:

254B.08 FEDERAL WAIVERS.

The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of services to persons who need ~~chemical dependency~~ substance use disorder services. The commissioner may seek amendments to the waivers or apply for additional waivers to contain costs. The commissioner shall ensure that payment for the cost of providing ~~chemical dependency~~ substance use disorder services under the federal waiver plan does not exceed the cost of ~~chemical dependency~~ substance use disorder services that would have been provided without the waivered services.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 64. Minnesota Statutes 2016, section 254B.09, is amended to read:

254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND.

Subdivision 1. **Vendor payments.** The commissioner shall pay eligible vendors for ~~chemical dependency~~ substance use disorder services to American Indians on the same basis as other payments, except that no local match is required when an invoice is submitted by the governing authority of a federally recognized American Indian tribal body or a county if the tribal governing body has not entered into an agreement under subdivision 2 on behalf of a current resident of the reservation under this section.

Subd. 2. **American Indian agreements.** The commissioner may enter into agreements with federally recognized tribal units to pay for ~~chemical dependency~~ substance use disorder treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must clarify how the governing body of the tribal unit fulfills local agency responsibilities regarding:

(1) the form and manner of invoicing; and

(2) provide that only invoices for eligible vendors according to section 254B.05 will be included in invoices sent to the commissioner for payment, to the extent that money allocated under subdivisions 4 and 5 is used.

Subd. 6. **American Indian tribal placements.** After entering into an agreement under subdivision 2, the governing authority of each reservation may submit invoices to the state for the cost of providing ~~chemical dependency~~ substance use disorder services to residents

of the reservation according to the placement rules governing county placements, except that local match requirements are waived. The governing body may designate an agency to act on its behalf to provide placement services and manage invoices by written notice to the commissioner and evidence of agreement by the agency designated.

Subd. 8. **Payments to improve services to American Indians.** The commissioner may set rates for ~~chemical dependency~~ substance use disorder services to American Indians according to the American Indian Health Improvement Act, Public Law 94-437, for eligible vendors. These rates shall supersede rates set in county purchase of service agreements when payments are made on behalf of clients eligible according to Public Law 94-437.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 65. Minnesota Statutes 2016, section 254B.12, subdivision 2, is amended to read:

Subd. 2. **Payment methodology for highly specialized vendors.** Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop separate payment methodologies for ~~chemical dependency~~ substance use disorder treatment services provided under the consolidated chemical dependency treatment fund: (1) by a state-operated vendor; or (2) for persons who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community. A payment methodology under this subdivision is effective for services provided on or after October 1, 2015, or on or after the receipt of federal approval, whichever is later.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 66. Minnesota Statutes 2016, section 254B.12, is amended by adding a subdivision to read:

Subd. 3. **Chemical dependency provider rate increase.** For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2017, payment rates shall be increased by one percent over the rates in effect on January 1, 2017, for vendors who meet the requirements of section 254B.05.

Sec. 67. Minnesota Statutes 2016, section 254B.13, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation in a navigator pilot program, an individual must:

(1) be a resident of a county with an approved navigator program;

(2) be eligible for consolidated chemical dependency treatment fund services;

(3) be a voluntary participant in the navigator program;

(4) satisfy one of the following items:

(i) have at least one severity rating of three or above in dimension four, five, or six in a comprehensive assessment under ~~Minnesota Rules, part 9530.6422~~ section 245G.05, paragraph (c), clauses (4) to (6); or

(ii) have at least one severity rating of two or above in dimension four, five, or six in a comprehensive assessment under ~~Minnesota Rules, part 9530.6422,~~ section 245G.05, paragraph (c), clauses (4) to (6), and be currently participating in a Rule 31 treatment program under ~~Minnesota Rules, parts 9530.6405 to 9530.6505,~~ chapter 245G or be within 60 days following discharge after participation in a Rule 31 treatment program; and

(5) have had at least two treatment episodes in the past two years, not limited to episodes reimbursed by the consolidated chemical dependency treatment funds. An admission to an emergency room, a detoxification program, or a hospital may be substituted for one treatment episode if it resulted from the individual's substance use disorder.

(b) New eligibility criteria may be added as mutually agreed upon by the commissioner and participating navigator programs.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 68. Minnesota Statutes 2016, section 256B.0625, subdivision 45a, is amended to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons under 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons ~~under~~ 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 develop admissions and discharge procedures and establish rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.~~

~~(d)~~ The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. 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.

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

Sec. 69. **[256B.0941] PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR PERSONS UNDER 21 YEARS OF AGE.**

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary by the state's medical review agent according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional licensed as defined in section 245.4871, subdivision 27, clauses (1) to (6).

(b) A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine medical necessity, including a standard diagnostic assessment completed within 180 days of the

individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services.

Subd. 2. **Services.** Psychiatric residential treatment facility service providers must offer and have the capacity to provide the following services:

(1) development of the individual plan of care, review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(2) any services provided by a psychiatrist or physician for development of an individual plan of care, conducting a review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(3) active treatment seven days per week that may include individual, family, or group therapy as determined by the individual care plan;

(4) individual therapy, provided a minimum of twice per week;

(5) family engagement activities, provided a minimum of once per week;

(6) consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff, or other support planners;

(7) coordination of educational services between local and resident school districts and the facility;

(8) 24-hour nursing; and

(9) direct care and supervision, supportive services for daily living and safety, and positive behavior management.

Subd. 3. **Per diem rate.** (a) The commissioner shall establish a statewide per diem rate for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The cost reporting shall be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services must be billed by the facility on a separate claim, and the facility shall be responsible for payment to the provider. These services must be included in the individual plan of care and are subject to prior authorization by the state's medical review agent.

(d) Medicaid shall reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision shall not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

Subd. 4. **Leave days.** (a) Medical assistance covers therapeutic and hospital leave days, provided the recipient was not discharged from the psychiatric residential treatment facility and is expected to return to the psychiatric residential treatment facility. A reserved bed must be held for a recipient on hospital leave or therapeutic leave.

(b) A therapeutic leave day to home shall be used to prepare for discharge and reintegration and shall be included in the individual plan of care. The state shall reimburse 75 percent of the per diem rate for a reserve bed day while the recipient is on therapeutic leave. A therapeutic leave visit may not exceed three days without prior authorization.

(c) A hospital leave day shall be a day for which a recipient has been admitted to a hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric residential treatment facility. The state shall reimburse 50 percent of the per diem rate for a reserve bed day while the recipient is receiving medical or psychiatric care in a hospital.

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

Sec. 70. Minnesota Statutes 2016, section 256B.0943, subdivision 13, is amended to read:

Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with severe emotional disturbance who is residing in a hospital; ~~a group home as defined in Minnesota Rules, parts 2960.0130 to 2960.0220;~~ a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential treatment facility under section 256B.0625, subdivision 45a; a regional treatment center; or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan.

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

Sec. 71. Minnesota Statutes 2016, section 256B.0945, subdivision 2, is amended to read:

Subd. 2. **Covered services.** All services must be included in a child's individualized treatment or multiagency plan of care as defined in chapter 245.

For facilities that are not institutions for mental diseases according to federal statute and regulation, medical assistance covers mental health-related services that are required to be provided by a residential facility under section 245.4882 and administrative rules promulgated thereunder, except for room and board. For residential facilities determined by the federal Centers for Medicare and Medicaid Services to be an institution for mental diseases, medical

assistance covers medically necessary mental health services provided by the facility according to section 256B.055, subdivision 13, except for room and board.

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, through April 30, 2019, and expires May 1, 2019.

Sec. 72. Minnesota Statutes 2016, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided under this section by a residential facility shall:

(1) for services provided by a residential facility that is not an institution for mental diseases, only be made of federal earnings for services provided ~~under this section~~, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board~~.~~; and

(2) for services provided by a residential facility that is determined to be an institution for mental diseases, be equivalent to the federal share of the payment that would have been made if the residential facility were not an institution for mental diseases. The portion of the payment representing what would be the nonfederal shares shall be paid by the county. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, through April 30, 2019, and expires May 1, 2019.

Sec. 73. Minnesota Statutes 2016, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The prepaid health plan must pass this rate increase to the providers identified in paragraphs (a), (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(h) For services described in paragraphs (b), (e), and (g) and rendered on or after July 1, 2017, payment rates for mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, that are not designated as essential community providers under section 62Q.19 shall be equal to payment rates for mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, that are designated as essential community providers under section 62Q.19. In order to receive increased payment rates under this paragraph, a provider must demonstrate a commitment to serve low-income and underserved populations by:

(1) charging for services on a sliding-fee schedule based on current poverty income guidelines; and

(2) not restricting access or services because of a client's financial limitation.

Sec. 74. **CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.**

The commissioner of human services shall conduct a comprehensive analysis of Minnesota's continuum of intensive mental health services and shall develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children currently being served in residential treatment. The commissioner's analysis shall include, but not be limited to:

(1) data related to access, utilization, efficacy, and outcomes for Minnesota's current system of residential mental health treatment for a child with a severe emotional disturbance;

(2) potential expansion of the state's psychiatric residential treatment facility (PRTF) capacity, including increasing the number of PRTF beds and conversion of existing children's mental health residential treatment programs into PRTFs;

(3) the capacity need for PRTF and other group settings within the state if adequate community-based alternatives are accessible, equitable, and effective statewide;

(4) recommendations for expanding alternative community-based service models to meet the needs of a child with a serious mental health disorder who would otherwise require residential treatment and potential service models that could be utilized, including data related to access, utilization, efficacy, and outcomes;

(5) models of care used in other states; and

(6) analysis and specific recommendations for the design and implementation of new service models, including analysis to inform rate setting as necessary.

The analysis shall be supported and informed by extensive stakeholder engagement. Stakeholders include individuals who receive services, family members of individuals who receive services, providers, counties, health plans, advocates, and others. Stakeholder engagement shall include interviews with key stakeholders, intentional outreach to individuals who receive services and the individual's family members, and regional listening sessions.

The commissioner shall provide a report with specific recommendations and timelines for implementation to the legislative committees with jurisdiction over children's mental health policy and finance by November 15, 2018.

Sec. 75. **RESIDENTIAL TREATMENT AND PAYMENT RATE REFORM.**

The commissioner shall contract with an outside expert to identify recommendations for the development of a substance use disorder residential treatment program model and payment structure that is not subject to the federal institutions for mental diseases exclusion and that is financially sustainable for providers, while incentivizing best practices and improved treatment outcomes. The analysis must include recommendations and a timeline for supporting providers to transition to the new models of care delivery. No later than December 15, 2018, the commissioner shall deliver a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 76. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes, in consultation with the with the Department of Human Services, shall make necessary cross-reference changes that are needed as a result of the enactment of sections 12 to 35 and 75. The revisor shall make any necessary technical and grammatical changes to preserve the meaning of the text.

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

Sec. 77. **REPEALER.**

(a) Minnesota Statutes 2016, sections 245A.1915; 245A.192; and 254A.02, subdivision 4, are repealed.

(b) Minnesota Rules, parts 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, and 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500; and 9530.6505, are repealed.

(c) Minnesota Statutes 2016, section 256B.7631, is repealed.

EFFECTIVE DATE. Paragraphs (a) and (b) are effective January 1, 2018. Paragraph (c) is effective the day following final enactment.

ARTICLE 9

OPERATIONS

Section 1. Minnesota Statutes 2016, section 245A.02, subdivision 2b, is amended to read:

Subd. 2b. **Annual or annually.** With the exception of subdivision 2c, "annual" or "annually" means prior to or within the same month of the subsequent calendar year.

Sec. 2. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to read:

Subd. 2c. **Annual or annually; family child care training requirements.** For the purposes of section 245A.50, subdivisions 1 to 9, "annual" or "annually" means the 12-month period beginning on the license effective date or the annual anniversary of the effective date and ending on the day prior to the annual anniversary of the license effective date.

Sec. 3. Minnesota Statutes 2016, section 245A.04, subdivision 4, is amended to read:

Subd. 4. **Inspections; waiver.** (a) Before issuing an initial license, 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; and

(4) observation of the program in operation.

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), is not required prior to issuing an initial license under subdivision 7. If the commissioner issues an initial license under subdivision 7, these requirements must be completed within one year after the issuance of an initial 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 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.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 4. Minnesota Statutes 2016, section 245A.06, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the Department of Human Services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be made in writing and must be postmarked and sent to the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

(b) This paragraph applies only to licensed family child care providers. A licensed family child care provider who requests reconsideration of a correction order under paragraph (a)

may also request, on a form and in the manner prescribed by the commissioner, that the commissioner expedite the review if:

(1) the provider is challenging a violation and provides a description of how complying with the corrective action for that violation would require the substantial expenditure of funds or a significant change to their program; and

(2) describes what actions the provider will take in lieu of the corrective action ordered to ensure the health and safety of children in care pending the commissioner's review of the correction order.

Sec. 5. Minnesota Statutes 2016, section 245A.06, subdivision 8, is amended to read:

Subd. 8. **Requirement to post correction order.** (a) For licensed family child care providers and child care centers, upon receipt of any correction order or order of conditional license issued by the commissioner under this section, and notwithstanding a pending request for reconsideration of the correction order or order of conditional license by the license holder, the license holder shall post the correction order or order of conditional license in a place that is conspicuous to the people receiving services and all visitors to the facility for two years. When the correction order or order of conditional license is accompanied by a maltreatment investigation memorandum prepared under section 626.556 or 626.557, the investigation memoranda must be posted with the correction order or order of conditional license.

(b) If the commissioner reverses or rescinds a violation in a correction order upon reconsideration under subdivision 2, the commissioner shall issue an amended correction order and the license holder shall post the amended order according to paragraph (a).

(c) If the correction order is rescinded or reversed in full upon reconsideration under subdivision 2, the license holder shall remove the original correction order posted according to paragraph (a).

Sec. 6. Minnesota Statutes 2016, section 245A.06, is amended by adding a subdivision to read:

Subd. 9. **Child care correction order quotas prohibited.** The commissioner and county licensing agencies shall not order, mandate, require, or suggest to any person responsible for licensing or inspecting a licensed family child care provider or child care center a quota for the issuance of correction orders on a daily, weekly, monthly, quarterly, or yearly basis.

Sec. 7. **[245A.065] CHILD CARE FIX-IT TICKET.**

(a) In lieu of a correction order under section 245A.06, the commissioner shall issue a fix-it ticket to a family child care or child care center license holder if the commissioner finds that:

(1) the license holder has failed to comply with a requirement in this chapter or Minnesota Rules, chapter 9502 or 9503, that the commissioner determines to be eligible for a fix-it ticket;

(2) the violation does not imminently endanger the health, safety, or rights of the persons served by the program;

(3) the license holder did not receive a fix-it ticket or correction order for the violation at the license holder's last licensing inspection;

(4) the violation can be corrected at the time of inspection or within 48 hours, excluding Saturdays, Sundays, and holidays; and

(5) the license holder corrects the violation at the time of inspection or agrees to correct the violation within 48 hours, excluding Saturdays, Sundays, and holidays.

(b) The fix-it ticket must state:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated; and

(3) that the violation was corrected at the time of inspection or must be corrected within 48 hours, excluding Saturdays, Sundays, and holidays.

(c) The commissioner shall not publicly publish a fix-it ticket on the department's Web site.

(d) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it ticket, the license holder must correct the violation and within one week submit evidence to the licensing agency that the violation was corrected.

(e) If the violation is not corrected at the time of inspection or within 48 hours, excluding Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to establish that the license holder corrected the violation, the commissioner must issue a correction order for the violation of Minnesota law or rule identified in the fix-it ticket according to section 245A.06.

(f) The commissioner shall, following consultation with family child care license holders, child care center license holders, and county agencies, issue a report by October 1, 2017, that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503, that are eligible for a fix-it ticket. The commissioner shall provide the report to county agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over child care, and shall post the report to the department's Web site.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 8. Minnesota Statutes 2016, 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;

(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 disqualification which has not been set aside under section 245C.22;

(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 who has had a license 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 the reasons the license was suspended, 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) and (h), 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, 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 ~~above~~ 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 August 1, 2017.

Sec. 9. **[245A.1434] INFORMATION FOR CHILD CARE LICENSE HOLDERS.**

The commissioner shall inform family child care and child care center license holders on a timely basis of changes to state and federal statute, rule, regulation, and policy relating to the provision of licensed child care, the child care assistance program under chapter 119B, the quality rating and improvement system under section 124D.142, and child care licensing functions delegated to counties. Communications under this section shall include information to promote license holder compliance with identified changes. Communications under this section may be accomplished by electronic means and shall be made available to the public online.

Sec. 10. **[245A.153] REPORT TO LEGISLATURE ON THE STATUS OF CHILD CARE.**

Subdivision 1. **Reporting requirements.** Beginning on February 1, 2018, and no later than February 1 of each year thereafter, the commissioner of human services shall provide a report on the status of child care in Minnesota to the chairs and ranking minority members of the legislative committees with jurisdiction over child care.

Subd. 2. **Contents of report.** (a) The report must include the following:

(1) summary data on trends in child care center and family child care capacity and availability throughout the state, including the number of centers and programs that have opened and closed and the geographic locations of those centers and programs;

(2) a description of any changes to statutes, administrative rules, or agency policies and procedures that were implemented in the year preceding the report;

(3) a description of the actions the department has taken to address or implement the recommendations from the Legislative Task Force on Access to Affordable Child Care Report dated January 15, 2017, including but not limited to actions taken in the areas of:

(i) encouraging uniformity in implementing and interpreting statutes, administrative rules, and agency policies and procedures relating to child care licensing and access;

(ii) improving communication with county licensors and child care providers regarding changes to statutes, administrative rules, and agency policies and procedures, ensuring that information is directly and regularly transmitted;

(iii) providing notice to child care providers before issuing correction orders or negative actions relating to recent changes to statutes, administrative rules, and agency policies and procedures;

(iv) implementing confidential, anonymous communication processes for child care providers to ask questions and receive prompt, clear answers from the department;

(v) streamlining processes to reduce duplication or overlap in paperwork and training requirements for child care providers; and

(vi) compiling and distributing information detailing trends in the violations for which correction orders and negative actions are issued;

(4) a description of the department's efforts to cooperate with counties while addressing and implementing the task force recommendations;

(5) summary data on child care assistance programs including but not limited to state funding and numbers of families served; and

(6) summary data on family child care correction orders, including:

(i) the number of licensed family child care provider appeals or requests for reconsideration of correction orders to the Department of Human Services;

(ii) the number of family child care correction order appeals or requests for reconsideration that the Department of Human Services grants; and

(iii) the number of family child care correction order appeals or requests for reconsideration that the Department of Human Services denies.

(b) The commissioner may offer recommendations for legislative action.

Subd. 3. **Sunset.** This section expires February 2, 2020.

Sec. 11. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The ~~county~~ local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally ~~unlicensed~~ nonlicensed child care, ~~juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county,~~ and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in juvenile correctional facilities listed under

section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482.

ARTICLE 10

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2016, 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, ~~environmental bore holes,~~ bored geothermal heat exchangers, and elevator ~~shafts~~ borings.

Sec. 2. Minnesota Statutes 2016, section 103I.005, subdivision 2a, is amended to read:

Subd. 2a. **Certified representative.** "Certified representative" means a person certified by the commissioner to represent a well contractor, limited well/boring contractor, ~~monitoring~~ environmental well contractor, or elevator boring contractor.

Sec. 3. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision 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.

Sec. 4. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision to read:

Subd. 8b. **Environmental well contractor.** "Environmental well contractor" means a person with an environmental well contractor's license issued by the commissioner.

Sec. 5. Minnesota Statutes 2016, section 103I.005, subdivision 12, is amended to read:

Subd. 12. **Limited well/boring contractor.** "Limited well/boring contractor" means a person with a limited well/boring contractor's license issued by the commissioner. Limited well/boring contractor's licenses are issued for:

(1) constructing, repairing, and sealing bored geothermal heat exchangers;

(2) installing, repairing, and modifying pitless units and pitless adaptors, well casings above the pitless unit or pitless adaptor, well screens, ~~or~~ well diameters~~; constructing, repairing, and sealing drive point wells or dug wells~~, and well pumps and pumping equipment;

(3) constructing, repairing, and sealing dewatering wells; and

(4) sealing wells~~; and installing well pumps or pumping equipment~~ and borings.

Sec. 6. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision to read:

Subd. 17a. **Temporary environmental well.** "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.

Sec. 7. Minnesota Statutes 2016, section 103I.005, subdivision 20a, is amended to read:

Subd. 20a. **Water supply well.** "Water supply well" means a well that is not a dewatering well or ~~monitoring~~ environmental well and includes wells used:

(1) for potable water supply;

(2) for irrigation;

(3) for agricultural, commercial, or industrial water supply;

(4) for heating or cooling; and

(5) ~~as a remedial well; and~~

~~(6)~~ for testing water yield for irrigation, commercial or industrial uses, residential supply, or public water supply.

Sec. 8. Minnesota Statutes 2016, section 103I.005, subdivision 21, is amended to read:

Subd. 21. **Well.** "Well" means an excavation that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed if the excavation is intended for the location, diversion, artificial recharge, monitoring, testing, remediation, or acquisition of groundwater. Well includes ~~monitoring~~ environmental wells, drive point wells, and dewatering wells. "Well" does not include:

(1) an excavation by backhoe, or otherwise for temporary dewatering of groundwater for nonpotable use during construction, if the depth of the excavation is 25 feet or less;

(2) an excavation made to obtain or prospect for oil, natural gas, minerals, or products of mining or quarrying;

(3) an excavation to insert media to repressure oil or natural gas bearing formations or to store petroleum, natural gas, or other products;

(4) an excavation for nonpotable use for wildfire suppression activities; or

(5) borings.

Sec. 9. Minnesota Statutes 2016, section 103I.101, subdivision 2, is amended to read:

Subd. 2. **Duties.** The commissioner shall:

(1) regulate the drilling, construction, modification, repair, and sealing of wells and borings;

(2) examine and license:

(i) well contractors;

(ii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

(iii) persons modifying or repairing well casings above the pitless unit or adaptor, well screens, ~~or~~ well diameters~~; persons constructing, repairing, and sealing drive point wells or dug wells~~, and installing well pumps or pumping equipment;

(iv) persons constructing, repairing, and sealing dewatering wells;

(v) persons sealing wells~~; persons installing well pumps or pumping equipment~~ or borings; and

(vi) persons excavating or drilling holes for the installation of elevator borings ~~or hydraulic cylinders~~;

(3) ~~register~~ examine and ~~examine monitoring~~ license environmental well contractors;

(4) license explorers engaged in exploratory boring and examine individuals who supervise or oversee exploratory boring;

(5) after consultation with the commissioner of natural resources and the Pollution Control Agency, establish standards for the design, location, construction, repair, and sealing of wells and borings within the state; and

(6) issue permits for wells, groundwater thermal devices, bored geothermal heat exchangers, and elevator borings.

Sec. 10. Minnesota Statutes 2016, section 103I.101, subdivision 5, is amended to read:

Subd. 5. **Commissioner to adopt rules.** The commissioner shall adopt rules including:

(1) issuance of licenses for:

(i) qualified well contractors~~, persons modifying or repairing well casings, well screens, or well diameters~~;

(ii) ~~persons constructing, repairing, and sealing drive point wells or dug wells;~~

~~(iii)~~ persons constructing, repairing, and sealing dewatering wells;

~~(iv)~~ (iii) persons sealing wells or borings;

~~(v)~~ (iv) persons installing, modifying, or repairing well casings, well screens, well diameters, and well pumps or pumping equipment;

~~(vi)~~ (v) persons constructing, repairing, and sealing bored geothermal heat exchangers; ~~and~~

~~(vii)~~ (vi) persons constructing, repairing, and sealing elevator borings; and

(vii) persons constructing, repairing, and sealing environmental wells;

(2) ~~issuance of registration for monitoring well contractors;~~

~~(3)~~ establishment of conditions for examination and review of applications for license and ~~registration~~ certification;

~~(4)~~ (3) establishment of conditions for revocation and suspension of license and ~~registration~~ certification;

~~(5)~~ (4) establishment of minimum standards for design, location, construction, repair, and sealing of wells and borings to implement the purpose and intent of this chapter;

~~(6)~~ (5) establishment of a system for reporting on wells and borings drilled and sealed;

~~(7)~~ (6) establishment of standards for the construction, maintenance, sealing, and water quality monitoring of wells in areas of known or suspected contamination;

~~(8)~~ (7) establishment of wellhead protection measures for wells serving public water supplies;

~~(9)~~ (8) establishment of procedures to coordinate collection of well and boring data with other state and local governmental agencies;

~~(10)~~ (9) establishment of criteria and procedures for submission of well and boring logs, formation samples or well or boring cuttings, water samples, or other special information required for and water resource mapping; and

~~(11)~~ (10) establishment of minimum standards for design, location, construction, maintenance, repair, sealing, safety, and resource conservation related to borings, including exploratory borings as defined in section 103I.005, subdivision 9.

Sec. 11. Minnesota Statutes 2016, section 103I.101, subdivision 6, is amended to read:

Subd. 6. **Fees for variances.** The commissioner shall charge a nonrefundable application fee of ~~$235~~ $275 to cover the administrative cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

Sec. 12. Minnesota Statutes 2016, section 103I.105, is amended to read:

103I.105 ADVISORY COUNCIL ON WELLS AND BORINGS.

(a) The Advisory Council on Wells and Borings is established as an advisory council to the commissioner. The advisory council shall consist of 18 voting members. Of the 18 voting members:

(1) one member must be from the Department of Health, appointed by the commissioner of health;

(2) one member must be from the Department of Natural Resources, appointed by the commissioner of natural resources;

(3) one member must be a member of the Minnesota Geological Survey of the University of Minnesota, appointed by the director;

(4) one member must be a responsible individual for a licensed explorer;

(5) one member must be a certified representative of a licensed elevator boring contractor;

(6) two members must be members of the public who are not connected with the boring or well drilling industry;

(7) one member must be from the Pollution Control Agency, appointed by the commissioner of the Pollution Control Agency;

(8) one member must be from the Department of Transportation, appointed by the commissioner of transportation;

(9) one member must be from the Board of Water and Soil Resources appointed by its chair;

(10) one member must be a certified representative of ~~a monitoring~~ an environmental well contractor;

(11) six members must be residents of this state appointed by the commissioner, who are certified representatives of licensed well contractors, with not more than two from the seven-county metropolitan area and at least four from other areas of the state who represent different geographical regions; and

(12) one member must be a certified representative of a licensed bored geothermal heat exchanger contractor.

(b) An appointee of the well drilling industry may not serve more than two consecutive terms.

(c) The appointees to the advisory council from the well drilling industry must:

(1) have been residents of this state for at least three years before appointment; and

(2) have at least five years' experience in the well drilling business.

(d) The terms of the appointed members and the compensation and removal of all members are governed by section 15.059.

Sec. 13. Minnesota Statutes 2016, section 103I.111, subdivision 6, is amended to read:

Subd. 6. **Unsealed wells and borings are public health nuisances.** A well or boring that is required to be sealed under section 103I.301 but is not sealed is a public health nuisance. A county may abate the unsealed well or boring with the same authority of a community health board to abate a public health nuisance under section 145A.04, subdivision 8.

Sec. 14. Minnesota Statutes 2016, section 103I.111, subdivision 8, is amended to read:

Subd. 8. **Municipal regulation of drilling.** A municipality may regulate all drilling, except well, elevator ~~shaft~~ boring, and exploratory drilling that is subject to the provisions of this chapter, above, in, through, and adjacent to subsurface areas designated for mined underground space development and existing mined underground space. The regulations may prohibit, restrict, control, and require permits for the drilling.

Sec. 15. Minnesota Statutes 2016, section 103I.205, subdivision 1, is amended to read:

Subdivision 1. **Notification required.** (a) Except as provided in ~~paragraphs~~ paragraph (d) ~~and (e)~~, 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 ~~(f)~~ (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.

(b) The property owner, the property owner's agent, or the ~~well~~ 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) A person may not construct a monitoring well until a permit is issued by the commissioner for the construction. If after obtaining a permit an attempt to construct a well is unsuccessful, a new permit is not required as long as the initial permit is modified to indicate the location of the successful well.~~

~~(f)~~ (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. 16. Minnesota Statutes 2016, section 103I.205, subdivision 2, is amended to read:

Subd. 2. **Emergency permit and notification exemptions.** The commissioner may adopt rules that modify the procedures for filing a well notification or well or boring permit if conditions occur that:

(1) endanger the public health and welfare or cause a need to protect the groundwater; or

(2) require the ~~monitoring~~ environmental well contractor, limited well/boring contractor, or well contractor to begin constructing a well or boring before obtaining a permit or notification.

Sec. 17. Minnesota Statutes 2016, section 103I.205, subdivision 3, is amended to read:

Subd. 3. **Maintenance permit.** (a) Except as provided under paragraph (b), a well that is not in use must be sealed or have a maintenance permit.

(b) If ~~a monitoring~~ an environmental well or a dewatering well is not sealed by 14 months after completion of construction, the owner of the property on which the well is located must obtain and annually renew a maintenance permit from the commissioner.

Sec. 18. Minnesota Statutes 2016, 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 ~~a monitoring~~ an environmental well 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 ~~register with~~ be licensed by the commissioner as ~~a monitoring~~ 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 ~~six~~ four activities:

(1) installing ~~or~~, repairing, and modifying well screens ~~or~~, pitless units ~~or~~ 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) ~~constructing, repairing, and sealing drive point wells or dug wells;~~

~~(3) installing well pumps or pumping equipment;~~

~~(4)~~ sealing wells and borings;

~~(5)~~ (3) constructing, repairing, ~~or~~ and sealing dewatering wells; or

~~(6)~~ (4) constructing, repairing, ~~or~~ 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 ~~or registration~~, a license ~~or registration~~ 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;

(2) an individual who performs labor or services for a contractor licensed ~~or registered~~ 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 ~~or registered~~ 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 ~~or registered~~ well contractor within 50 miles, and (ii) the licensed plumber complies with all relevant sections of the plumbing code.

Sec. 19. Minnesota Statutes 2016, section 103I.205, subdivision 5, is amended to read:

Subd. 5. **At-grade ~~monitoring~~ environmental wells.** At-grade ~~monitoring~~ environmental wells are authorized without variance and may be installed for the purpose of evaluating groundwater conditions or for use as a leak detection device. An at-grade ~~monitoring~~ environmental well must be installed in accordance with the rules of the commissioner. The at-grade ~~monitoring~~ environmental wells must be installed with an impermeable double locking cap approved by the commissioner and must be labeled environmental or monitoring wells.

Sec. 20. Minnesota Statutes 2016, section 103I.205, subdivision 6, is amended to read:

Subd. 6. **Distance requirements for sources of contamination, buildings, gas pipes, liquid propane tanks, and electric lines.** (a) A person may not place, construct, or install an actual or potential source of contamination, building, gas pipe, liquid propane tank, or electric line any closer to a well or boring than the isolation distances prescribed by the commissioner by rule unless a variance has been prescribed by rule.

(b) The commissioner shall establish by rule reduced isolation distances for facilities which have safeguards in accordance with sections 18B.01, subdivision 26, and 18C.005, subdivision 29.

Sec. 21. Minnesota Statutes 2016, 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 ~~new~~ water supply well, ~~$235~~ $275, which includes the state core function fee;

(2) for a well sealing, ~~$65~~ $75 for each well, which includes the state core function fee, except that a single fee of $75 is required for ~~monitoring~~ all temporary environmental wells ~~constructed on~~ recorded on the sealing notification for a single property, having depths within a 25 foot range, and sealed within ~~48~~ 72 hours of start of construction~~, a single fee of $65~~; ~~and~~

(3) for construction of a dewatering well, ~~$235~~ $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 ~~$1,175~~ $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.

Sec. 22. Minnesota Statutes 2016, section 103I.208, subdivision 2, is amended to read:

Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

(1) for a water supply well that is not in use under a maintenance permit, $175 annually;

(2) ~~for construction of a monitoring well, $235, which includes the state core function fee;~~

~~(3)~~ for ~~a monitoring~~ an environmental well that is unsealed under a maintenance permit, $175 annually except no fee is required for an environmental well owned by a federal agency, state agency, or local unit of government that is unsealed under a maintenance permit. "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the

joint exercise of powers under section 471.59, a community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management;

~~(4) for a monitoring well owned by a federal agency, state agency, or local unit of government that is unsealed under a maintenance permit, $50 annually. "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the joint exercise of powers under section 471.59, a community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management;~~

~~(5)~~ (3) for ~~monitoring~~ environmental wells ~~used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is $235, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for~~ that are unsealed under a maintenance permit ~~for unsealed monitoring wells is,~~ $175 annually per site regardless of the number of ~~monitoring~~ environmental wells located on site;

~~(6)~~ (4) for a groundwater thermal exchange device, in addition to the notification fee for water supply wells, ~~$235~~ $275, which includes the state core function fee;

~~(7)~~ (5) for a bored geothermal heat exchanger with less than ten tons of heating/cooling capacity, ~~$235~~ $275;

~~(8)~~ (6) for a bored geothermal heat exchanger with ten to 50 tons of heating/cooling capacity, ~~$475~~ $515;

~~(9)~~ (7) for a bored geothermal heat exchanger with greater than 50 tons of heating/cooling capacity, ~~$700~~ $740;

~~(10)~~ (8) for a dewatering well that is unsealed under a maintenance permit, $175 annually for each dewatering well, except a dewatering project comprising more than five dewatering wells shall be issued a single permit for $875 annually for dewatering wells recorded on the permit; and

~~(11)~~ (9) for an elevator boring, ~~$235~~ $275 for each boring.

Sec. 23. Minnesota Statutes 2016, section 103I.235, is amended by adding a subdivision to read:

Subd. 3. **Temporary environmental well and unsuccessful well exemption.** This section does not apply to temporary environmental wells or unsuccessful wells that have been sealed by a licensed contractor in compliance with this chapter.

Sec. 24. Minnesota Statutes 2016, section 103I.301, subdivision 1, is amended to read:

Subdivision 1. **Wells and borings.** (a) A property owner must have a well or boring sealed if:

(1) the well or boring is contaminated or may contribute to the spread of contamination;

(2) the well or boring was attempted to be sealed but was not sealed according to the provisions of this chapter; or

(3) the well or boring is located, constructed, or maintained in a manner that its continued use or existence endangers groundwater quality or is a safety or health hazard.

(b) A well or boring that is not in use must be sealed unless the property owner has a maintenance permit for the well.

(c) The property owner must have a well or boring sealed by a ~~registered or~~ licensed person authorized to seal the well or boring, consistent with provisions of this chapter.

Sec. 25. Minnesota Statutes 2016, section 103I.301, subdivision 2, is amended to read:

Subd. 2. ~~**Monitoring**~~ **Environmental wells.** The owner of the property where ~~a monitoring~~ an environmental well is located must have the ~~monitoring~~ environmental well sealed when the well is no longer in use. The owner must have a well contractor, limited well/boring sealing contractor, or ~~a monitoring~~ an environmental well contractor seal the ~~monitoring~~ environmental well.

Sec. 26. Minnesota Statutes 2016, section 103I.315, subdivision 1, is amended to read:

Subdivision 1. **Order to seal well or boring.** The commissioner may order a property owner to seal a well or boring if:

(1) the commissioner determines that without being sealed the well or boring is an imminent threat to public health or public safety;

(2) the well or boring is required to be sealed under section 103I.301; or

(3) a well is ~~a monitoring~~ an environmental well or dewatering well and by 14 months after construction of the well, the owner has not obtained a maintenance permit, or after a maintenance permit has been issued the owner has not renewed a maintenance permit.

Sec. 27. Minnesota Statutes 2016, section 103I.501, is amended to read:

103I.501 LICENSING AND REGULATION OF WELLS AND BORINGS.

(a) The commissioner shall regulate and license:

(1) drilling, constructing, and repair of wells;

(2) sealing of wells;

(3) installing of well pumps and pumping equipment;

(4) excavating, drilling, repairing, and sealing of elevator borings;

(5) construction, repair, and sealing of environmental ~~bore holes~~ wells; and

(6) construction, repair, and sealing of bored geothermal heat exchangers.

(b) The commissioner shall examine and license well contractors, limited well/boring contractors, ~~and~~ elevator boring contractors, and ~~examine and register monitoring~~ environmental well contractors.

(c) The commissioner shall license explorers engaged in exploratory boring and shall examine persons who supervise or oversee exploratory boring.

Sec. 28. Minnesota Statutes 2016, section 103I.505, subdivision 1, is amended to read:

Subdivision 1. **Reciprocity authorized.** The commissioner may issue a license or ~~register~~ certify a person under this chapter, without giving an examination, if the person is licensed or ~~registered~~ certified in another state and:

(1) the requirements for licensing or ~~registration~~ certification under which the well or boring contractor was licensed or ~~registered~~ person was certified do not conflict with this chapter;

(2) the requirements are of a standard not lower than that specified by the rules adopted under this chapter; and

(3) equal reciprocal privileges are granted to licensees or ~~registrants~~ certified persons of this state.

Sec. 29. Minnesota Statutes 2016, section 103I.505, subdivision 2, is amended to read:

Subd. 2. **Fees required.** A well or boring contractor or certified person must apply for the license or ~~registration~~ certification and pay the fees under the provisions of this chapter to receive a license or ~~registration~~ certification under this section.

Sec. 30. Minnesota Statutes 2016, section 103I.515, is amended to read:

103I.515 LICENSES NOT TRANSFERABLE.

A license or ~~registration~~ certification issued under this chapter is not transferable.

Sec. 31. Minnesota Statutes 2016, section 103I.525, subdivision 1, is amended to read:

Subdivision 1. **Certification application.** (a) A person must file an application and application fee with the commissioner to represent a well contractor.

(b) The application must state the applicant's qualifications for certification as a representative, and other information required by the commissioner. The application must be on forms prescribed by the commissioner.

~~(c) A person may apply as an individual if the person:~~

~~(1) is not representing a firm, sole proprietorship, partnership, association, corporation, or other entity including the United States government, any interstate body, the state, and an agency, department, or political subdivision of the state; and~~

~~(2) meets the well contractor certification and license requirements under this chapter.~~

Sec. 32. Minnesota Statutes 2016, section 103I.525, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of a well contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a well contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 33. Minnesota Statutes 2016, section 103I.525, subdivision 5, is amended to read:

Subd. 5. **Bond.** (a) As a condition of being issued a well contractor's license, the applicant~~,~~ ~~except a person applying for an individual well contractor's license,~~ must submit a corporate surety bond for $25,000 approved by the commissioner. The bond must be conditioned to pay the state on performance of work in this state that is not in compliance with this chapter or rules adopted under this chapter. The bond is in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of the bond, the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 34. Minnesota Statutes 2016, section 103I.525, subdivision 6, is amended to read:

Subd. 6. **License fee.** The fee for a well contractor's license is $250~~, except the fee for an individual well contractor's license is $75~~.

Sec. 35. Minnesota Statutes 2016, section 103I.525, subdivision 8, is amended to read:

Subd. 8. **Renewal.** (a) A licensee must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee for a well contractor's license is $250~~, except the fee for an individual well contractor's license is $75~~.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well and boring construction reports, well and boring sealing reports, reports of elevator borings, water sample analysis reports, well and boring permits, and well notifications for work conducted by the licensee since the last license renewal.

Sec. 36. Minnesota Statutes 2016, section 103I.531, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of a limited well/boring contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a limited well/boring contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

(c) The fee for three or more limited well/boring contractor certifications is $225.

(d) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 37. Minnesota Statutes 2016, section 103I.531, subdivision 5, is amended to read:

Subd. 5. **Bond.** (a) As a condition of being issued a limited well/boring contractor's license for ~~constructing, repairing, and sealing drive point wells or dug wells,~~ sealing wells ~~or~~ and borings, constructing, repairing, and sealing dewatering wells, or constructing, repairing, and sealing bored geothermal heat exchangers, the applicant must submit a corporate surety bond for $10,000 approved by the commissioner. As a condition of being issued a limited well/boring contractor's license for installing ~~or~~, repairing, and modifying well pumps and pumping equipment, well screens ~~or~~, pitless units ~~or~~ and pitless adaptors, and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing, ~~or installing well pumps or pumping equipment,~~ the applicant must submit a corporate surety bond for $2,000 approved by the commissioner. The bonds required in this paragraph must be conditioned to pay the state on performance of work in this state that is not in compliance with this chapter or rules adopted under this chapter. The bonds are in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of a bond required in paragraph (a), the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 38. Minnesota Statutes 2016, section 103I.535, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of an elevator boring contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of an elevator boring contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 39. Minnesota Statutes 2016, section 103I.535, subdivision 6, is amended to read:

Subd. 6. **License fee.** The fee for an elevator ~~shaft~~ boring contractor's license is $75.

Sec. 40. Minnesota Statutes 2016, section 103I.541, subdivision 1, is amended to read:

Subdivision 1. ~~**Registration**~~ **Certification.** A person seeking ~~registration as a monitoring~~ certification to represent an environmental well contractor must meet examination and experience requirements adopted by the commissioner by rule.

Sec. 41. Minnesota Statutes 2016, section 103I.541, subdivision 2, is amended to read:

Subd. 2. **Validity.** ~~A monitoring~~ An environmental well contractor's ~~registration~~ certification is valid until the date prescribed in the ~~registration~~ certification by the commissioner.

Sec. 42. Minnesota Statutes 2016, section 103I.541, subdivision 2a, is amended to read:

Subd. 2a. **Certification application.** (a) An individual must submit an application and application fee to the commissioner to apply for certification as a representative of ~~a~~ ~~monitoring~~ an environmental well contractor.

(b) The application must be on forms prescribed by the commissioner. The application must state the applicant's qualifications for the certification, and other information required by the commissioner.

Sec. 43. Minnesota Statutes 2016, section 103I.541, subdivision 2b, is amended to read:

Subd. 2b. **Issuance of ~~registration~~ license.** If a person employs a certified representative, submits the bond under subdivision 3, and pays the ~~registration~~ license fee of $75 for ~~a~~ ~~monitoring~~ an environmental well contractor ~~registration~~ license, the commissioner shall issue ~~a monitoring~~ an environmental well contractor ~~registration~~ license to the applicant. The fee for an individual registration is $75. The commissioner may not act on an application until the application fee is paid.

Sec. 44. Minnesota Statutes 2016, section 103I.541, subdivision 2c, is amended to read:

Subd. 2c. **Certification fee.** (a) The application fee for certification as a representative of ~~a monitoring~~ an environmental well contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of ~~a monitoring~~ an environmental well contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 45. Minnesota Statutes 2016, section 103I.541, subdivision 2e, is amended to read:

Subd. 2e. **Issuance of certification.** If the applicant meets the experience requirements established by rule and passes the examination as determined by the commissioner, the commissioner shall issue the applicant a certification to represent ~~a monitoring~~ an environmental well contractor.

Sec. 46. Minnesota Statutes 2016, section 103I.541, subdivision 3, is amended to read:

Subd. 3. **Bond.** (a) As a condition of being issued ~~a monitoring~~ an environmental well contractor's ~~registration~~ license, the applicant must submit a corporate surety bond for $10,000 approved by the commissioner. The bond must be conditioned to pay the state on performance of work in this state that is not in compliance with this chapter or rules adopted under this chapter. The bond is in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of the bond, the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 47. Minnesota Statutes 2016, section 103I.541, subdivision 4, is amended to read:

Subd. 4. **License renewal.** (a) A person must file an application and a renewal application fee to renew the ~~registration~~ license by the date stated in the ~~registration~~ license.

(b) The renewal application fee for ~~a monitoring~~ an environmental well contractor's ~~registration~~ license is $75.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all well and boring construction reports, well and boring sealing reports, well permits, and notifications for work conducted by the ~~registered~~ licensed person since the last ~~registration~~ license renewal.

Sec. 48. Minnesota Statutes 2016, section 103I.541, subdivision 5, is amended to read:

Subd. 5. **Incomplete or late renewal.** If a ~~registered~~ licensed person submits a renewal application after the required renewal date:

(1) the ~~registered~~ licensed person must include a late fee of $75; and

(2) the ~~registered~~ licensed person may not conduct activities authorized by the ~~monitoring~~ environmental well contractor's ~~registration~~ license until the renewal application, renewal application fee, late fee, and all other information required in subdivision 4 are submitted.

Sec. 49. Minnesota Statutes 2016, section 103I.545, is amended to read:

103I.545 REGISTRATION OF DRILLING MACHINES AND HOISTS REQUIRED.

Subdivision 1. **Drilling machine.** (a) A person may not use a drilling machine such as a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license ~~or registration~~ under this chapter unless the drilling machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a $75 registration fee.

(c) A registration is valid for one year.

Subd. 2. **Hoist.** (a) A person may not use a machine such as a hoist for an activity requiring a license ~~or registration~~ under this chapter to repair wells or borings, seal wells or borings, or install pumps unless the machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a $75 registration fee.

(c) A registration is valid for one year.

Sec. 50. **[103I.550] LIMITED PUMP, PITLESS, OR DUG WELL/DRIVE POINT CONTRACTOR.**

Subdivision 1. **Limited pump or pitless license or certification.** A person with a limited well/boring contractor's license or certification to install well pumps and pumping equipment;

or a person with a limited well/boring contractor's license or certification to install, repair, and modify pitless units and pitless adapters, well casings above the pitless unit or pitless adapter, and well screens and well diameters, will be issued a combined license or certification to: (1) install well pumps and pumping equipment; and (2) install, repair, and modify pitless units and pitless adapters, well casings above the pitless unit or pitless adapter, well screens, and well diameters.

Subd. 2. **Limited dug well/drive point license or certification.** A person with a limited well/boring contractor's license or certification to construct, repair, and seal drive point wells and dug wells will be issued a well contractor's license or certification.

Sec. 51. Minnesota Statutes 2016, section 103I.601, subdivision 2, is amended to read:

Subd. 2. **License required to make borings.** (a) Except as provided in paragraph (d), a person must not make an exploratory boring without an explorer's license. The fee for an explorer's license is $75. The explorer's license is valid until the date prescribed in the license by the commissioner.

(b) A person must file an application and renewal application fee to renew the explorer's license by the date stated in the license. The renewal application fee is $75.

(c) If the licensee submits an application fee after the required renewal date, the licensee:

(1) must include a late fee of $75; and

(2) may not conduct activities authorized by an explorer's license until the renewal application, renewal application fee, late fee, and sealing reports required in subdivision 9 are submitted.

(d) An explorer must designate a responsible individual to supervise and oversee the making of exploratory borings.

(1) Before an individual supervises or oversees an exploratory boring, the individual must file an application and application fee of $75 to qualify as a certified responsible individual.

(2) The individual must take and pass an examination relating to construction, location, and sealing of exploratory borings. A professional engineer or geoscientist licensed under sections 326.02 to 326.15 or a professional geologist certified by the American Institute of Professional Geologists is not required to take the examination required in this subdivision, but must be certified as a responsible individual to supervise an exploratory boring.

(3) The individual must file an application and a renewal fee of $75 to renew the responsible individual's certification by the date stated in the certification. If the certified responsible individual submits an application fee after the renewal date, the certified responsible individual must include a late fee of $75 and may not supervise or oversee exploratory borings until the renewal application, application fee, and late fee are submitted.

Sec. 52. Minnesota Statutes 2016, 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, 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 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. 53. Minnesota Statutes 2016, section 103I.711, subdivision 1, is amended to read:

Subdivision 1. **Impoundment.** The commissioner may apply to district court for a warrant authorizing seizure and impoundment of all drilling machines or hoists owned or used by a person. The court shall issue an impoundment order upon the commissioner's showing that a person is constructing, repairing, or sealing wells or borings or installing pumps or pumping equipment or excavating holes for installing elevator ~~shafts~~ borings without a license ~~or registration~~ as required under this chapter. A sheriff on receipt of the warrant must seize and impound all drilling machines and hoists owned or used by the person. A person from whom equipment is seized under this subdivision may file an action in district court for the purpose of establishing that the equipment was wrongfully seized.

Sec. 54. Minnesota Statutes 2016, section 103I.715, subdivision 2, is amended to read:

Subd. 2. **Gross misdemeanors.** A person is guilty of a gross misdemeanor who:

(1) willfully violates a provision of this chapter or order of the commissioner;

(2) engages in the business of drilling or making wells, sealing wells, installing pumps or pumping equipment, or constructing elevator ~~shafts~~ borings without a license required by this chapter; or

(3) engages in the business of exploratory boring without an exploratory borer's license under this chapter.

Sec. 55. **[137.67] MINNESOTA BIOMEDICINE AND BIOETHICS INNOVATION GRANTS.**

Subdivision 1. **Grants.** (a) The steering committee of the University of Minnesota and Mayo Foundation partnership shall award grants to entities that apply for a grant under this subdivision to fund innovations and research in biomedicine and bioethics. Grant funds must be used to fund biomedical and bioethical research, and related clinical translation and commercialization activities in this state. Entities must apply for a grant in a form and manner specified by the steering committee. The steering committee shall use the following criteria to award grants under this subdivision:

(1) the likelihood that the research will lead to a new discovery;

(2) the prospects for commercialization of the research;

(3) the likelihood that the research will strengthen Minnesota's economy through the creation of new businesses, increased public or private funding for research in Minnesota, or attracting additional clinicians and researchers to Minnesota; and

(4) whether the proposed research includes a bioethics research plan to ensure the research is conducted using ethical research practices.

(b) Projects that include the acquisition or use of human fetal tissue are not eligible for grants under this subdivision. For purposes of this paragraph, "human fetal tissue" has the meaning given in United States Code, title 42, section 289g-1(f).

Subd. 2. **Consultation.** In awarding grants under subdivision 1, the steering committee may consult with interested parties who are able to provide technical information, advice, and recommendations on grant projects and awards. Interested parties with whom the steering committee may consult include but are not limited to representatives of private industries with expertise in biomedical research, bioethical research, clinical translation, commercialization, and medical venture financing.

Sec. 56. **[144.0572] CRIMINAL HISTORY BACKGROUND CHECKS ON APPLICANTS, LICENSEES, AND OTHER OCCUPATIONS REGULATED BY COMMISSIONER OF HEALTH.**

Subdivision 1. **Criminal history background check requirements.** (a) Beginning January 1, 2018, an applicant for initial licensure, temporary licensure, or relicensure after a lapse in licensure as an audiologist or speech-language pathologist, or an applicant for initial certification as a hearing instrument dispenser, must submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension (BCA) and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation (FBI).

(b) Beginning January 1, 2020, an applicant for a renewal license or certificate as an audiologist, speech-language pathologist, or hearing instrument dispenser who was licensed or obtained a certificate before January 1, 2018, must submit to a criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI.

(c) An applicant must submit to a background study under chapter 245C.

(d) The criminal history records check must be structured so that any new crimes that an applicant or licensee or certificate holder commits after the initial background check are flagged in the BCA's or FBI's database and reported back to the commissioner of human services.

Subd. 2. **Procedures.** (a) The commissioner shall contract with the Department of Human Services to process the criminal history background check requirements through NETStudy 2.0, as defined in section 245C.02.

(b) The Department of Human Services shall conduct the criminal history background checks according to section 144.057, except that:

(1) all applicants must submit to a fingerprint-based criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI;

(2) the Department of Human Services shall complete the check and the study and notify the commissioner of health if the applicant, licensee, or certificate holder has a criminal history as defined in section 245C.15; and

(3) the Department of Human Services shall simultaneously conduct a background study on each applicant according to chapter 245C.

(c) When making a determination whether to issue a license, deny a license, or issue a conditional license or other credential to practice an occupation regulated by the Department of Health, the commissioner or the commissioner's designee shall evaluate a criminal conviction, guilty plea, Alford plea, judicial determination, or preponderance of evidence to determine an applicant's risk of harm using the criteria in section 364.03.

(d) Before taking disciplinary action against an applicant or a licensee based on a criminal conviction, judicial determination, admission in court, Alford plea, or preponderance of evidence, the commissioner of health shall provide the applicant or licensee an opportunity to complete or challenge the accuracy of the criminal history information. The applicant or licensee shall have 30 calendar days following notice from the commissioner of the intent to deny licensure or take disciplinary action to request an opportunity to correct or complete the record prior to the commissioner taking disciplinary action. The commissioner shall provide the applicant up to 180 days to challenge the accuracy or completeness of the report with the agency responsible for the record. This subdivision does not affect the right of the subject of the data to contest the accuracy or completeness under section 13.04, subdivision 4.

(e) The checks and studies must be structured so that any new crimes that an applicant or licensee commits after the initial background check are flagged in the BCA's or FBI's database and reported back to the commissioner of human services.

Subd. 3. **Applicant, licensee, or other regulated individual's responsibilities.** (a) Applicants, licensees, and individuals seeking a credential to practice one of the public health occupations listed in subdivision 1 must submit a complete criminal history records check consent form, a complete background study consent form, and a full set of fingerprints as required by the Department of Human Services in section 245C.05.

(b) The applicant or license holder is responsible for paying to the Department of Human Services all fees associated with the preparation of the fingerprints, the criminal records check consent form, and the criminal background check.

Sec. 57. **[144.059] PALLIATIVE CARE ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The Palliative Care Advisory Council shall consist of 18 public members.

Subd. 2. **Public members.** (a) The commissioner shall appoint, in the manner provided in section 15.0597, 18 public members, including the following:

(1) two physicians, of which one is certified by the American Board of Hospice and Palliative Medicine;

(2) two registered nurses or advanced practice registered nurses, of which one is certified by the National Board for Certification of Hospice and Palliative Nurses;

(3) one care coordinator experienced in working with people with serious or chronic illness and their families;

(4) one spiritual counselor experienced in working with people with serious or chronic illness and their families;

(5) three licensed health professionals, such as complementary and alternative health care practitioners, dietitians or nutritionists, pharmacists, or physical therapists, who are neither physicians nor nurses, but who have experience as members of a palliative care interdisciplinary team working with people with serious or chronic illness and their families;

(6) one licensed social worker experienced in working with people with serious or chronic illness and their families;

(7) four patients or personal caregivers experienced with serious or chronic illness;

(8) one representative of a health plan company;

(9) one physician assistant that is a member of the American Academy of Hospice and Palliative Medicine; and

(10) two members from any of the categories described in clauses (1) to (9).

(b) Council membership must include, where possible, representation that is racially, culturally, linguistically, geographically, and economically diverse.

(c) The council must include at least six members who reside outside Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Sibley, Stearns, Washington, or Wright Counties.

(d) To the extent possible, council membership must include persons who have experience in palliative care research, palliative care instruction in a medical or nursing school setting, palliative care services for veterans as a provider or recipient, or pediatric care.

(e) Council membership must include health professionals who have palliative care work experience or expertise in palliative care delivery models in a variety of inpatient, outpatient, and community settings, including acute care, long-term care, or hospice, with a variety of populations, including pediatric, youth, and adult patients.

Subd. 3. **Term.** Members of the council shall serve for a term of three years and may be reappointed. Members shall serve until their successors have been appointed.

Subd. 4. **Administration.** The commissioner or the commissioner's designee shall provide meeting space and administrative services for the council.

Subd. 5. **Chairs.** At the council's first meeting, and biannually thereafter, the members shall elect a chair and a vice-chair whose duties shall be established by the council.

Subd. 6. **Meeting.** The council shall meet at least twice yearly.

Subd. 7. **No compensation.** Public members of the council serve without compensation or reimbursement for expenses.

Subd. 8. **Duties.** (a) The council shall consult with and advise the commissioner on matters related to the establishment, maintenance, operation, and outcomes evaluation of palliative care initiatives in the state.

(b) By February 15 of each year, the council shall submit to the chairs and ranking minority members of the committees of the senate and the house of representatives with primary jurisdiction over health care a report containing:

(1) the advisory council's assessment of the availability of palliative care in the state;

(2) the advisory council's analysis of barriers to greater access to palliative care; and

(3) recommendations for legislative action, with draft legislation to implement the recommendations.

(c) The Department of Health shall publish the report each year on the department's Web site.

Subd. 9. **Open meetings.** The council is subject to the requirements of chapter 13D.

Subd. 10. **Sunset.** The council shall sunset January 1, 2025.

Sec. 58. **[144.1215] AUTHORIZATION TO USE HANDHELD DENTAL X-RAY EQUIPMENT.**

Subdivision 1. **Definition; handheld dental x-ray equipment.** For purposes of this section, "handheld dental x-ray equipment" means x-ray equipment that is used to take dental radiographs, is designed to be handheld during operation, and is operated by an individual authorized to take dental radiographs under chapter 150A.

Subd. 2. **Use authorized.** (a) Handheld dental x-ray equipment may be used if the equipment:

(1) has been approved for human use by the United States Food and Drug Administration and is being used in a manner consistent with that approval; and

(2) utilizes a backscatter shield that:

(i) is composed of a leaded polymer or a substance with a substantially equivalent protective capacity;

(ii) has at least 0.25 millimeters of lead or lead-shielding equivalent; and

(iii) is permanently affixed to the handheld dental x-ray equipment.

(b) The use of handheld dental x-ray equipment is prohibited if the equipment's backscatter shield is broken or not permanently affixed to the system.

(c) The use of handheld dental x-ray equipment shall not be limited to situations in which it is impractical to transfer the patient to a stationary x-ray system.

(d) Handheld dental x-ray equipment must be stored when not in use, by being secured in a restricted, locked area of the facility.

(e) Handheld dental x-ray equipment must be calibrated initially and at intervals that must not exceed 24 months. Calibration must include the test specified in Minnesota Rules, part 4732.1100, subpart 11.

(f) Notwithstanding Minnesota Rules, part 4732.0880, subpart 2, item C, the tube housing and the position-indicating device of handheld dental x-ray equipment may be handheld during an exposure.

Subd. 3. **Exemptions from certain shielding requirements.** Handheld dental x-ray equipment used according to this section and according to manufacturer instructions is exempt from the following requirements for the equipment:

(1) shielding requirements in Minnesota Rules, part 4732.0365, item B; and

(2) requirements for the location of the x-ray control console or utilization of a protective barrier in Minnesota Rules, part 4732.0800, subpart 2, item B, subitems (2) and (3), provided the equipment utilizes a backscatter shield that satisfies the requirements in subdivision 2, paragraph (a), clause (2).

Subd. 4. **Compliance with rules.** A registrant using handheld dental x-ray equipment shall otherwise comply with Minnesota Rules, chapter 4732.

Sec. 59. Minnesota Statutes 2016, section 144.122, is amended to read:

144.122 LICENSE, PERMIT, AND SURVEY FEES.

(a) The state commissioner of health, by rule, may prescribe procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the Department of Management and Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with disabilities program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	$7,655 plus $16 per bed
Non-JCAHO and non-AOA hospitals	$5,280 plus $250 per bed
Nursing home	$183 plus $91 per bed until June 30, 2018. $183 plus $100 per bed between July 1, 2018,

	and June 30, 2019. $183 plus $105 per bed beginning July 1, 2019.

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	$3,712
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017, or later.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$	900
Swing bed surveys for nursing homes	$	1,200
Psychiatric hospitals	$	1,400
Rural health facilities	$	1,100
Portable x-ray providers	$	500
Home health agencies	$	1,800
Outpatient therapy agencies	$	800
End stage renal dialysis providers	$	2,100
Independent therapists	$	800
Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 60. Minnesota Statutes 2016, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents and mental health professionals agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; ~~or~~ a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not

committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 61. **[144.1505] HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION GRANT PROGRAM.**

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(1) "eligible advanced practice registered nurse program" means a program that is located in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level advanced practice registered nurse program by the Commission on Collegiate Nursing Education or by the Accreditation Commission for Education in Nursing, or is a candidate for accreditation;

(2) "eligible dental therapy program" means a dental therapy education program or advanced dental therapy education program that is located in Minnesota and is either:

(i) approved by the Board of Dentistry; or

(ii) currently accredited by the Commission on Dental Accreditation;

(3) "eligible mental health professional program" means a program that is located in Minnesota and is listed as a mental health professional program by the appropriate accrediting body for clinical social work, psychology, marriage and family therapy, or licensed professional clinical counseling, or is a candidate for accreditation;

(4) "eligible pharmacy program" means a program that is located in Minnesota and is currently accredited as a doctor of pharmacy program by the Accreditation Council on Pharmacy Education;

(5) "eligible physician assistant program" means a program that is located in Minnesota and is currently accredited as a physician assistant program by the Accreditation Review Commission on Education for the Physician Assistant, or is a candidate for accreditation;

(6) "mental health professional" means an individual providing clinical services in the treatment of mental illness who meets one of the qualifications under section 245.462, subdivision 18; and

(7) "project" means a project to establish or expand clinical training for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, or mental health professionals in Minnesota.

Subd. 2. **Program.** (a) The commissioner of health shall award health professional training site grants to eligible physician assistant, advanced practice registered nurse,

pharmacy, dental therapy, and mental health professional programs to plan and implement expanded clinical training. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 for the first year, $100,000 for the second year, and $50,000 for the third year per program.

(b) Funds may be used for:

(1) establishing or expanding clinical training for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental health professionals in Minnesota;

(2) recruitment, training, and retention of students and faculty;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship activities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy, dental therapy, or mental health professional training program; and

(9) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected; and a plan to maintain or operate any component included in the project after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the application is complete and whether the program and the

project are eligible for a grant. In evaluating applications, the commissioner shall score each application based on factors including, but not limited to, the applicant's clarity and thoroughness in describing the project and the problems to be addressed, the extent to which the applicant has demonstrated that the applicant has made adequate provisions to ensure proper and efficient operation of the training program once the grant project is completed, the extent to which the proposed project is consistent with the goal of increasing access to primary care and mental health services for rural and underserved urban communities, the extent to which the proposed project incorporates team-based primary care, and project costs and use of funds.

Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible program based on the relative score of each eligible program's application, other relevant factors discussed during the review, and the funds available to the commissioner. Appropriations made to the program do not cancel and are available until expended. During the grant period, the commissioner may require and collect from programs receiving grants any information necessary to evaluate the program.

Sec. 62. **[144.4199] PUBLIC HEALTH RESPONSE CONTINGENCY ACCOUNT.**

Subdivision 1. **Public health response contingency account.** A public health response contingency account is created in the special revenue fund in the state treasury. Money in the public health response contingency account does not cancel and is appropriated to the commissioner of health for the purposes specified in subdivision 4 when the determination criteria in subdivision 3 and the requirements in subdivisions 5, paragraph (a), and 7, are satisfied.

Subd. 2. **Definition.** For purposes of this section, "public health response" means immediate public health activities required to protect the health and safety of the public due to pandemic influenza or an outbreak of a communicable or infectious disease.

Subd. 3. **Determination criteria.** The commissioner may make expenditures from the public health response contingency account only if:

(1) the commissioner determines the pandemic influenza or outbreak of a communicable or infectious disease requires a public health response;

(2) the commissioner determines that the public health response is reasonably expected to require supplies, equipment, personnel, and other resources in excess of the resources available for public health response and preparedness activities in the affected jurisdictions; and

(3) the commissioner has notified the relevant federal agency that the pandemic influenza or communicable or infectious disease:

(i) is reasonably expected to require the evacuation of the impacted population, relocation of seriously ill or injured persons to temporary care facilities, or the provision of replacement essential community services;

(ii) poses a probability of a large number of deaths, serious injuries, or long-term disabilities in the affected population;

(iii) involves widespread exposure to an infectious agent that poses a significant risk of substantial future harm to a large number of people in the affected area; or

(iv) poses a significant risk of harm to a large number of people or a high rate of morbidity or mortality in the affected population.

Subd. 4. **Uses of funds.** (a) When the determination criteria in subdivision 3 are satisfied and the commissioner has complied with subdivisions 5, paragraph (a), and 7, the commissioner may make expenditures from the public health response contingency account for the following purposes attributable to a public health response:

(1) staffing;

(2) information technology;

(3) supplies, equipment, and services to protect people in the affected area or population, health care providers, and public safety workers;

(4) training for and coordination with local public health departments and health care providers;

(5) communication with and outreach to affected areas or populations;

(6) to provide a state match for federal assistance obtained for the public health response;

(7) laboratory testing, including enhancements to laboratory capacity necessary to conduct testing related to the event, and supplies, equipment, shipping, and security;

(8) the purchase of vaccines, antibiotics, antivirals, and other medical resources to prevent the spread of the pandemic influenza or communicable or infectious disease or to treat related medical conditions;

(9) reimbursement to community health boards or other local units of government for incurred costs for the goods and services listed in clauses (1) to (8) that are attributable to the public health response;

(10) reimbursement to health care organizations and health care providers for incurred costs that are attributable to the public health response; and

(11) funding to support other state agencies for costs incurred by those agencies that are attributable to the public health response.

(b) Money in the account must not be used to increase the total number of full-time equivalent permanent employees at the Department of Health, unless expressly authorized by law. Money in the account shall be used only for public health response activities to protect the health and safety of the public.

Subd. 5. **Assistance from other sources.** (a) As a condition of making expenditures from the public health response contingency account, the commissioner must seek any appropriate assistance from other available sources, including the federal government, to assist with costs attributable to the public health response.

(b) If the commissioner recovers eligible costs for the public health response from a nonstate source after making expenditures from the public health response contingency account, the commissioner shall reimburse the public health response contingency account for those costs, up to the amount recovered for eligible costs from the nonstate source.

Subd. 6. **Emergency management authority.** Nothing in this section shall be construed to limit the emergency management authority of the governor or any local or county organization for emergency management under chapter 12 or other law.

Subd. 7. **Notice and expenditure review.** (a) For pandemic influenza or an outbreak of a communicable or infectious disease that begins on or after July 1, 2017, if the commissioner determines that a public health response to pandemic influenza or an outbreak of a communicable or infectious disease may require the diversion of Department of Health staff or resources, the commissioner shall provide written notice to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance with information on the event requiring the public health response, the public health response that may be required, and estimates of the staff hours and resources that the commissioner may need to divert to provide the public health response. For pandemic influenza or an outbreak of a communicable or infectious disease that begins prior to July 1, 2017, the commissioner must provide the notice required by this paragraph no later than July 10, 2017.

(b) Prior to authorizing expenditures from the public health response contingency account, the commissioner shall seek review and recommendation from the Legislative Advisory Commission according to the procedures in section 3.3005, subdivision 5, that would

otherwise apply if the funds were federal funds. The commissioner is prohibited from seeking review and recommendation for any expenditures for public health response activities that were made before the commissioner provided the notice required in paragraph (a).

Subd. 8. **Report.** By January 15 of each year, the commissioner shall submit a report to the chairs and ranking minority members of the house of representatives Ways and Means Committee, the senate Finance Committee, and the house of representatives and senate committees with jurisdiction over health and human services finance, detailing expenditures made in the previous calendar year from the public health response contingency account.

Sec. 63. Minnesota Statutes 2016, section 144.4961, subdivision 3, is amended to read:

Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules establishing licensure requirements and work standards relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings. Rules adopted by the commissioner under this subdivision are effective beginning January 1, 2019.

Sec. 64. Minnesota Statutes 2016, section 144.4961, subdivision 4, is amended to read:

Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after January 1, ~~2018~~ 2019, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

Sec. 65. Minnesota Statutes 2016, section 144.4961, subdivision 5, is amended to read:

Subd. 5. **License required annually.** Effective January 1, ~~2018~~ 2019, a license is required annually for every person, firm, or corporation that performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere.

Sec. 66. Minnesota Statutes 2016, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed

capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does

not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance or MinnesotaCare;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital 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 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete; ~~or~~

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of

admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review; or

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission.

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

Sec. 67. Minnesota Statutes 2016, 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; 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. 68. Minnesota Statutes 2016, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, and renewal.** (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, 2019, 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, 2019, 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

~~(d)~~ (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.

~~(e)~~ (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.

~~(f)~~ (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.

~~(g)~~ (i) 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.

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

Sec. 69. Minnesota Statutes 2016, 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 the use of technology in home and telehealth capabilities;

(6) 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) 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. 70. Minnesota Statutes 2016, section 144A.70, is amended by adding a subdivision to read:

Subd. 4a. **Nurse.** "Nurse" means a licensed practical nurse as defined in section 148.171, subdivision 8, or a registered nurse as defined in section 148.171, subdivision 20.

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

Sec. 71. Minnesota Statutes 2016, section 144A.70, subdivision 6, is amended to read:

Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies~~, and other licensed health professionals~~. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency does not include a professional home care agency licensed under section 144A.471 that only provides staff to other home care providers.

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

Sec. 72. Minnesota Statutes 2016, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a ~~description~~ conspicuous notice informing the tenant of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Sec. 73. Minnesota Statutes 2016, section 144D.06, is amended to read:

144D.06 OTHER LAWS.

In addition to registration under this chapter, a housing with services establishment must comply with chapter 504B and the provisions of section 325F.72, and shall obtain and maintain all other licenses, permits, registrations, or other governmental approvals required of it ~~in addition to registration under this chapter~~. A housing with services establishment is

~~subject to the provisions of section 325F.72 and chapter 504B~~ not required to obtain a lodging license under chapter 157 and related rules.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 74. **[144H.01] DEFINITIONS.**

Subdivision 1. **Application.** The terms defined in this section apply to this chapter.

Subd. 2. **Basic services.** "Basic services" includes but is not limited to:

(1) the development, implementation, and monitoring of a comprehensive protocol of care that is developed in conjunction with the parent or guardian of a medically complex or technologically dependent child and that specifies the medical, nursing, psychosocial, and developmental therapies required by the medically complex or technologically dependent child; and

(2) the caregiver training needs of the child's parent or guardian.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Licensee.** "Licensee" means an owner of a prescribed pediatric extended care (PPEC) center licensed under this chapter.

Subd. 5. **Medically complex or technologically dependent child.** "Medically complex or technologically dependent child" means a child under 21 years of age who, because of a medical condition, requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse.

Subd. 6. **Owner.** "Owner" means an individual whose ownership interest provides sufficient authority or control to affect or change decisions regarding the operation of the PPEC center. An owner includes a sole proprietor, a general partner, or any other individual whose ownership interest has the ability to affect the management and direction of the PPEC center's policies.

Subd. 7. **Prescribed pediatric extended care center, PPEC center, or center.** "Prescribed pediatric extended care center," "PPEC center," or "center" means any facility that provides nonresidential basic services to three or more medically complex or technologically dependent children who require such services and who are not related to the owner by blood, marriage, or adoption.

Subd. 8. **Supportive services or contracted services.** "Supportive services or contracted services" include but are not limited to speech therapy, occupational therapy, physical therapy, social work services, developmental services, child life services, and psychology services.

Sec. 75. **[144H.02] LICENSURE REQUIRED.**

A person may not own or operate a prescribed pediatric extended care center in this state unless the person holds a temporary or current license issued under this chapter. A separate license must be obtained for each PPEC center maintained on separate premises, even if the same management operates the PPEC centers. Separate licenses are not required for separate buildings on the same grounds. A center shall not be operated on the same grounds as a child care center licensed under Minnesota Rules, chapter 9503.

Sec. 76. **[144H.03] EXEMPTIONS.**

This chapter does not apply to:

(1) a facility operated by the United States government or a federal agency; or

(2) a health care facility licensed under chapter 144 or 144A.

Sec. 77. **[144H.04] LICENSE APPLICATION AND RENEWAL.**

Subdivision 1. **Licenses.** A person seeking licensure for a PPEC center must submit a completed application for licensure to the commissioner, in a form and manner determined by the commissioner. The applicant must also submit the application fee, in the amount specified in section 144H.05, subdivision 1. Effective January 1, 2018, the commissioner shall issue a license for a PPEC center if the commissioner determines that the applicant and center meet the requirements of this chapter and rules that apply to PPEC centers. A license issued under this subdivision is valid for two years.

Subd. 2. **License renewal.** A license issued under subdivision 1 may be renewed for a period of two years if the licensee:

(1) submits an application for renewal in a form and manner determined by the commissioner, at least 30 days before the license expires. An application for renewal submitted after the renewal deadline date must be accompanied by a late fee in the amount specified in section 144H.05, subdivision 3;

(2) submits the renewal fee in the amount specified in section 144H.05, subdivision 2;

(3) demonstrates that the licensee has provided basic services at the PPEC center within the past two years;

(4) provides evidence that the applicant meets the requirements for licensure; and

(5) provides other information required by the commissioner.

Subd. 3. **License not transferable.** A PPEC center license issued under this section is not transferable to another party. Before acquiring ownership of a PPEC center, a prospective applicant must apply to the commissioner for a new license.

Sec. 78. **[144H.05] FEES.**

Subdivision 1. **Initial application fee.** The initial application fee for PPEC center licensure is $3,820.

Subd. 2. **License renewal.** The fee for renewal of a PPEC center license is $1,800.

Subd. 3. **Late fee.** The fee for late submission of an application to renew a PPEC center license is $25.

Subd. 4. **Change of ownership.** The fee for change of ownership of a PPEC center is $4,200.

Subd. 5. **Nonrefundable; state government special revenue fund.** All fees collected under this chapter are nonrefundable and must be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 79. **[144H.06] APPLICATION OF RULES FOR HOSPICE SERVICES AND RESIDENTIAL HOSPICE FACILITIES.**

Minnesota Rules, chapter 4664, shall apply to PPEC centers licensed under this chapter, except that the following parts, subparts, items, and subitems do not apply:

(1) Minnesota Rules, part 4664.0003, subparts 2, 6, 7, 11, 12, 13, 14, and 38;

(2) Minnesota Rules, part 4664.0008;

(3) Minnesota Rules, part 4664.0010, subparts 3; 4, items A, subitem (6), and B; and 8;

(4) Minnesota Rules, part 4664.0020, subpart 13;

(5) Minnesota Rules, part 4664.0370, subpart 1;

(6) Minnesota Rules, part 4664.0390, subpart 1, items A, C, and E;

(7) Minnesota Rules, part 4664.0420;

(8) Minnesota Rules, part 4664.0425, subparts 3, item A; 4; and 6;

(9) Minnesota Rules, part 4664.0430, subparts 3, 4, 5, 7, 8, 9, 10, 11, and 12;

(10) Minnesota Rules, part 4664.0490; and

(11) Minnesota Rules, part 4664.0520.

Sec. 80. **[144H.07] SERVICES; LIMITATIONS.**

Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex or technologically dependent children, based on a protocol of care established for each child. A PPEC center may provide services up to 14 hours a day and up to six days a week.

Subd. 2. **Limitations.** A PPEC center must comply with the following standards related to services:

(1) a child is prohibited from attending a PPEC center for more than 14 hours within a 24-hour period;

(2) a PPEC center is prohibited from providing services other than those provided to medically complex or technologically dependent children; and

(3) the maximum capacity for medically complex or technologically dependent children at a center shall not exceed 45 children.

Sec. 81. **[144H.08] ADMINISTRATION AND MANAGEMENT.**

Subdivision 1. **Duties of owner.** (a) The owner of a PPEC center shall have full legal authority and responsibility for the operation of the center. A PPEC center must be organized according to a written table of organization, describing the lines of authority and communication to the child care level. The organizational structure must be designed to ensure an integrated continuum of services for the children served.

(b) The owner must designate one person as a center administrator, who is responsible and accountable for overall management of the center.

Subd. 2. **Duties of administrator.** The center administrator is responsible and accountable for overall management of the center. The administrator must:

(1) designate in writing a person to be responsible for the center when the administrator is absent from the center for more than 24 hours;

(2) maintain the following written records, in a place and form and using a system that allows for inspection of the records by the commissioner during normal business hours:

(i) a daily census record, which indicates the number of children currently receiving services at the center;

(ii) a record of all accidents or unusual incidents involving any child or staff member that caused, or had the potential to cause, injury or harm to a person at the center or to center property;

(iii) copies of all current agreements with providers of supportive services or contracted services;

(iv) copies of all current agreements with consultants employed by the center, documentation of each consultant's visits, and written, dated reports; and

(v) a personnel record for each employee, which must include an application for employment, references, employment history for the preceding five years, and copies of all performance evaluations;

(3) develop and maintain a current job description for each employee;

(4) provide necessary qualified personnel and ancillary services to ensure the health, safety, and proper care for each child; and

(5) develop and implement infection control policies that comply with rules adopted by the commissioner regarding infection control.

Sec. 82. **[144H.09] ADMISSION, TRANSFER, AND DISCHARGE POLICIES; CONSENT FORM.**

Subdivision 1. **Written policies.** A PPEC center must have written policies and procedures governing the admission, transfer, and discharge of children.

Subd. 2. **Notice of discharge.** At least ten days prior to a child's discharge from a PPEC center, the PPEC center shall provide notice of the discharge to the child's parent or guardian.

Subd. 3. **Consent form.** A parent or guardian must sign a consent form outlining the purpose of a PPEC center, specifying family responsibilities, authorizing treatment and services, providing appropriate liability releases, and specifying emergency disposition plans, before the child's admission to the center. The center must provide the child's parents or guardians with a copy of the consent form and must maintain the consent form in the child's medical record.

Sec. 83. **[144H.10] MEDICAL DIRECTOR.**

A PPEC center must have a medical director who is a physician licensed in Minnesota and certified by the American Board of Pediatrics.

Sec. 84. **[144H.11] NURSING SERVICES.**

Subdivision 1. **Nursing director.** A PPEC center must have a nursing director who is a registered nurse licensed in Minnesota, holds a current certification in cardiopulmonary resuscitation, and has at least four years of general pediatric nursing experience, at least one year of which must have been spent caring for medically fragile infants or children in a pediatric intensive care, neonatal intensive care, PPEC center, or home care setting during the previous five years. The nursing director is responsible for the daily operation of the PPEC center.

Subd. 2. **Registered nurses.** A registered nurse employed by a PPEC center must be a registered nurse licensed in Minnesota, hold a current certification in cardiopulmonary resuscitation, and have experience in the previous 24 months in being responsible for the care of acutely ill or chronically ill children.

Subd. 3. **Licensed practical nurses.** A licensed practical nurse employed by a PPEC center must be supervised by a registered nurse and must be a licensed practical nurse licensed in Minnesota, have at least two years of experience in pediatrics, and hold a current certification in cardiopulmonary resuscitation.

Subd. 4. **Other direct care personnel.** (a) Direct care personnel governed by this subdivision include nursing assistants and individuals with training and experience in the field of education, social services, or child care.

(b) All direct care personnel employed by a PPEC center must work under the supervision of a registered nurse and are responsible for providing direct care to children at the center. Direct care personnel must have extensive, documented education and skills training in providing care to infants and toddlers, provide employment references documenting skill in the care of infants and children, and hold a current certification in cardiopulmonary resuscitation.

Sec. 85. **[144H.12] TOTAL STAFFING FOR NURSING SERVICES AND DIRECT CARE PERSONNEL.**

A PPEC center must provide total staffing for nursing services and direct care personnel at a ratio of one staff person for every three children at the center. The staffing ratio required in this section is the minimum staffing permitted.

Sec. 86. **[144H.13] MEDICAL RECORD; PROTOCOL OF CARE.**

A medical record and an individualized nursing protocol of care must be developed for each child admitted to a PPEC center, must be maintained for each child, and must be signed by authorized personnel.

Sec. 87. **[144H.14] QUALITY ASSURANCE PROGRAM.**

A PPEC center must have a quality assurance program, in which quarterly reviews are conducted of the PPEC center's medical records and protocols of care for at least half of the children served by the PPEC center. The quarterly review sample must be randomly selected so each child at the center has an equal opportunity to be included in the review. The committee conducting quality assurance reviews must include the medical director, administrator, nursing director, and three other committee members determined by the PPEC center.

Sec. 88. **[144H.15] INSPECTIONS.**

(a) The commissioner may inspect a PPEC center, including records held at the center, at reasonable times as necessary to ensure compliance with this chapter and the rules that apply to PPEC centers. During an inspection, a center must provide the commissioner with access to all center records.

(b) The commissioner must inspect a PPEC center before issuing or renewing a license under this chapter.

Sec. 89. **[144H.16] COMPLIANCE WITH OTHER LAWS.**

Subdivision 1. **Reporting of maltreatment of minors.** A PPEC center must develop policies and procedures for reporting suspected child maltreatment that fulfill the requirements of section 626.556. The policies and procedures must include the telephone numbers of the local county child protection agency for reporting suspected maltreatment. The policies and procedures specified in this subdivision must be provided to the parents

or guardians of all children at the time of admission to the PPEC center and must be available upon request.

Subd. 2. **Crib safety requirements.** A PPEC center must comply with the crib safety requirements in section 245A.146, to the extent they are applicable.

Sec. 90. **[144H.17] DENIAL, SUSPENSION, REVOCATION, REFUSAL TO RENEW A LICENSE.**

(a) The commissioner may deny, suspend, revoke, or refuse to renew a license issued under this chapter for:

(1) a violation of this chapter or rules adopted that apply to PPEC centers; or

(2) an intentional or negligent act by an employee or contractor at the center that detrimentally affects the health or safety of children at the PPEC center.

(b) Prior to any suspension, revocation, or refusal to renew a license, a licensee shall be entitled to a hearing and review as provided in sections 14.57 to 14.69.

Sec. 91. **[144H.18] FINES; CORRECTIVE ACTION PLANS.**

Subdivision 1. **Corrective action plans.** If the commissioner determines that a PPEC center is not in compliance with this chapter or rules that apply to PPEC centers, the commissioner may require the center to submit a corrective action plan that demonstrates a good-faith effort to remedy each violation by a specific date, subject to approval by the commissioner.

Subd. 2. **Fines.** The commissioner may issue a fine to a PPEC center, employee, or contractor if the commissioner determines the center, employee, or contractor violated this chapter or rules that apply to PPEC centers. The fine amount shall not exceed an amount for each violation and an aggregate amount established by the commissioner. The failure to correct a violation by the date set by the commissioner, or a failure to comply with an approved corrective action plan, constitutes a separate violation for each day the failure continues, unless the commissioner approves an extension to a specific date. In determining if a fine is to be imposed and establishing the amount of the fine, the commissioner shall consider:

(1) the gravity of the violation, including the probability that death or serious physical or emotional harm to a child will result or has resulted, the severity of the actual or potential harm, and the extent to which the applicable laws were violated;

(2) actions taken by the owner or administrator to correct violations;

(3) any previous violations; and

(4) the financial benefit to the PPEC center of committing or continuing the violation.

Subd. 3. **Fines for violations of other statutes.** The commissioner shall impose a fine of $250 on a PPEC center, employee, or contractor for each violation by that PPEC center, employee, or contractor of section 144H.16, subdivision 2, or 626.556.

Sec. 92. **[144H.19] CLOSING A PPEC CENTER.**

When a PPEC center voluntarily closes, it must, at least 30 days before closure, inform each child's parents or guardians of the closure and when the closure will occur.

Sec. 93. **[144H.20] PHYSICAL ENVIRONMENT.**

Subdivision 1. **General requirements.** A PPEC center shall conform with or exceed the physical environment requirements in this section and the physical environment requirements for day care facilities in Minnesota Rules, part 9502.0425. If the physical environment requirements in this section differ from the physical environment requirements for day care facilities in Minnesota Rules, part 9502.0425, the requirements in this section shall prevail. A PPEC center must have sufficient indoor and outdoor space to accommodate at least six medically complex or technologically dependent children.

Subd. 2. **Specific requirements.** (a) The entrance to a PPEC center must be barrier-free, have a wheelchair ramp, provide for traffic flow with a driveway area for entering and exiting, and have storage space for supplies from home.

(b) A PPEC center must have a treatment room with a medication preparation area. The medication preparation area must contain a work counter, refrigerator, sink with hot and cold running water, and locked storage for biologicals and prescription drugs.

(c) A PPEC center must develop isolation procedures to prevent cross-infections and must have an isolation room with at least one glass area for observation of a child in the isolation room. The isolation room must be at least 100 square feet in size.

(d) A PPEC center must have:

(1) an outdoor play space adjacent to the center of at least 35 square feet per child in attendance at the center, for regular use; or

(2) a park, playground, or play space within 1,500 feet of the center.

(e) A PPEC center must have at least 50 square feet of usable indoor space per child in attendance at the center.

(f) Notwithstanding the Minnesota State Building Code and the Minnesota State Fire Code, a new construction PPEC center or an existing building converted into a PPEC center must meet the requirements of the International Building Code in Minnesota Rules, chapter 1305, for:

(1) Group R, Division 4 occupancy, if serving 12 or fewer children; or

(2) Group E, Division 4 occupancy or Group I, Division 4 occupancy, if serving 13 or more children.

Sec. 94. Minnesota Statutes 2016, section 145.4131, subdivision 1, is amended to read:

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

(1) the number of abortions performed by the physician in the previous calendar year, reported by month;

(2) the method used for each abortion;

(3) the approximate gestational age expressed in one of the following increments:

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

(4) the age of the woman at the time the abortion was performed;

(5) the specific reason for the abortion, including, but not limited to, the following:

(i) the pregnancy was a result of rape;

(ii) the pregnancy was a result of incest;

(iii) economic reasons;

(iv) the woman does not want children at this time;

(v) the woman's emotional health is at stake;

(vi) the woman's physical health is at stake;

(vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;

(viii) the pregnancy resulted in fetal anomalies; or

(ix) unknown or the woman refused to answer;

(6) the number of prior induced abortions;

(7) the number of prior spontaneous abortions;

(8) whether the abortion was paid for by:

(i) private coverage;

(ii) public assistance health coverage; or

(iii) self-pay;

(9) whether coverage was under:

(i) a fee-for-service plan;

(ii) a capitated private plan; or

(iii) other;

(10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form;

(11) the medical specialty of the physician performing the abortion; ~~and~~

(12) if the abortion was performed via telemedicine, the facility code for the patient and the facility code for the physician; and

~~(12)~~ (13) whether the abortion resulted in a born alive infant, as defined in section 145.423, subdivision 4, and:

(i) any medical actions taken to preserve the life of the born alive infant;

(ii) whether the born alive infant survived; and

(iii) the status of the born alive infant, should the infant survive, if known.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 95. Minnesota Statutes 2016, section 145.4716, subdivision 2, is amended to read:

Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible for the following:

(1) developing and providing comprehensive training on sexual exploitation of youth for social service professionals, medical professionals, public health workers, and criminal justice professionals;

(2) collecting, organizing, maintaining, and disseminating information on sexual exploitation and services across the state, including maintaining a list of resources on the Department of Health Web site;

(3) monitoring and applying for federal funding for antitrafficking efforts that may benefit victims in the state;

(4) managing grant programs established under sections 145.4716 to 145.4718~~, and~~; 609.3241, paragraph (c), clause (3); and 609.5315, subdivision 5c, clause (3);

(5) managing the request for proposals for grants for comprehensive services, including trauma-informed, culturally specific services;

(6) identifying best practices in serving sexually exploited youth, as defined in section 260C.007, subdivision 31;

(7) providing oversight of and technical support to regional navigators pursuant to section 145.4717;

(8) conducting a comprehensive evaluation of the statewide program for safe harbor of sexually exploited youth; and

(9) developing a policy consistent with the requirements of chapter 13 for sharing data related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among regional navigators and community-based advocates.

Sec. 96. Minnesota Statutes 2016, section 145.928, subdivision 13, is amended to read:

Subd. 13. **Reports.** (a) The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

(b) The commissioner shall release an annual report to the public and submit ~~an~~ the annual report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over public health on grants made under subdivision 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide specific information on the amount of each grant awarded to each agency or organization, an itemized list submitted to the commissioner by each agency or organization awarded a grant specifying all uses of grant funds and the amount expended for each use, the population served by each agency or organization, outcomes of the programs funded by each grant, and the amount of the appropriation retained by the commissioner for administrative and associated expenses. The commissioner shall issue a report each January 15 for the previous fiscal year beginning January 15, 2016.

Sec. 97. Minnesota Statutes 2016, 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 strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco. 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.

(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.

(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. 98. Minnesota Statutes 2016, section 146B.02, subdivision 2, is amended to read:

Subd. 2. **Requirements and term of license.** (a) Each application for an initial mobile or fixed-site establishment license and for renewal must be submitted to the commissioner on a form provided by the commissioner accompanied with the applicable fee required under section 146B.10. The application must contain:

(1) the name(s) of the owner(s) and operator(s) of the establishment;

(2) the location of the establishment;

(3) verification of compliance with all applicable local and state codes;

(4) a description of the general nature of the business; and

(5) any other relevant information deemed necessary by the commissioner.

(b) If the information submitted is complete and complies with the requirements of this chapter, the commissioner shall issue a provisional establishment license. The provisional license is effective until the commissioner determines, after inspection, that the applicant has met the requirements of this chapter. Upon approval, the commissioner shall issue a body art establishment license ~~effective for three years~~.

(c) An establishment license must be renewed every two years.

Sec. 99. Minnesota Statutes 2016, section 146B.02, subdivision 3, is amended to read:

Subd. 3. **Inspection.** (a) ~~Within the period of the provisional establishment license, and~~ The commissioner must inspect an establishment issued a provisional license within one year of the date the license was issued. Thereafter at least one time during each ~~three-year~~ two-year licensure period, the commissioner shall conduct an inspection of the body art establishment and a review of any records necessary to ensure that the standards required under this chapter are met.

(b) The commissioner shall have the authority to enter a premises to make an inspection. Refusal to permit an inspection constitutes valid grounds for licensure denial or revocation.

(c) If the establishment seeking licensure is new construction or if a licensed establishment is remodeling, the establishment must meet all local building and zoning codes.

Sec. 100. Minnesota Statutes 2016, section 146B.02, subdivision 5, is amended to read:

Subd. 5. **Transfer of ownership, relocation, and display of license.** (a) A body art establishment license must be issued to a specific person and location and is not transferable. A license must be prominently displayed in a public area of the establishment.

(b) An owner who has purchased a body art establishment licensed under the previous owner must submit an application to license the establishment within two weeks of the date of sale. Notwithstanding subdivision 1, the new owner may continue to operate for 60 days after the sale while waiting for a new license to be issued.

(c) An owner of a licensed body art establishment who is relocating the establishment must submit an application for the new location. The owner may request that the new application become effective at a specified date in the future. If the relocation is not accomplished by the date expected, and the license at the existing location expires, the owner may apply for a temporary event permit to continue to operate at the old location. The owner may apply for no more than four temporary event permits to continue operating at the old location.

Sec. 101. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision to read:

Subd. 7a. **Supervisors.** (a) Only a technician who has been licensed as a body artist for at least two years in Minnesota or in a jurisdiction with which Minnesota has reciprocity may supervise a temporary technician.

(b) Any technician who agrees to supervise more than two temporary technicians during the same time period must provide to the commissioner a supervisory plan that describes how the technician will provide supervision to each temporary technician in accordance with section 146B.01, subdivision 28.

(c) The commissioner may refuse to approve as a supervisor a technician who has been disciplined in Minnesota or in another jurisdiction after considering the criteria described in subdivision 10, paragraph (b).

Sec. 102. Minnesota Statutes 2016, section 146B.02, subdivision 8, is amended to read:

Subd. 8. **Temporary ~~events~~ event permit.** (a) An ~~owner or operator of a~~ applicant for a permit to hold a temporary body art ~~establishment~~ event shall submit an application ~~for a temporary events permit~~ to the commissioner. The application must be received at least 14 days before the start of the event. The application must include the specific days and hours

of operation. ~~The owner or operator~~ An applicant issued a temporary event permit shall comply with the requirements of this chapter.

(b) Applications received less than 14 days prior to the start of the event may be processed if the commissioner determines it is possible to conduct ~~the~~ all required work, including an inspection.

(c) The temporary ~~events~~ event permit must be prominently displayed in a public area at the location.

(d) The temporary ~~events~~ event permit, if approved, is valid for the specified dates and hours listed on the application. No temporary events permit shall be issued for longer than a 21-day period, and may not be extended.

(e) No individual who does not hold a current body art establishment license may be issued a temporary event permit more than four times within the same calendar year.

(f) No individual who has been disciplined for a serious violation of this chapter within three years preceding the intended start date of a temporary event may be issued a license for a temporary event. Violations that preclude issuance of a temporary event permit include unlicensed practice; practice in an unlicensed location; any of the conditions listed in section 146B.05, clauses (1) to (8), (12), or (13); 146B.08, subdivision 3, clauses (4), (5), and (10) to (12); or any other violation that places the health or safety of a client at risk.

Sec. 103. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision to read:

Subd. 10. **Licensure precluded.** (a) The commissioner may choose to deny a body art establishment license to an applicant who has been disciplined for a serious violation under this chapter. Violations that constitute grounds for denial of license are any of the conditions listed in section 146B.05, subdivision 1, clauses (1) to (8), (12), or (13); 146B.08, subdivision 3, clauses (4), (5), or (10) to (12); or any other violation that places the health or safety of a client at risk.

(b) In considering whether to grant a license to an applicant who has been disciplined for a violation described in this subdivision, the commissioner shall consider evidence of rehabilitation, including the nature and seriousness of the violation, circumstances relative to the violation, the length of time elapsed since the violation, and evidence that demonstrates that the applicant has maintained safe, ethical, and responsible body art practice since the time of the most recent violation.

Sec. 104. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision to read:

Subd. 11. **Penalties.** Any person who violates the provisions of subdivision 1 or who performs body art in an unlicensed location is guilty of a gross misdemeanor.

Sec. 105. Minnesota Statutes 2016, section 146B.03, subdivision 6, is amended to read:

Subd. 6. **Licensure term; renewal.** (a) A technician's license is valid for two years from the date of issuance and may be renewed upon payment of the renewal fee established under section 146B.10.

(b) At renewal, a licensee must submit proof of continuing education approved by the commissioner in the areas identified in subdivision 4.

(c) The commissioner shall notify the technician of the pending expiration of a technician license at least 60 days prior to license expiration.

(d) A technician previously licensed in Minnesota whose license has lapsed for less than six years may apply to renew. A technician previously licensed in Minnesota whose license has lapsed for less than ten years and who was licensed in another jurisdiction or jurisdictions during the entire time of lapse may apply to renew, but must submit proof of licensure in good standing in all other jurisdictions in which the technician was licensed as a body artist during the time of lapse. A technician previously licensed in Minnesota whose license has lapsed for more than six years and who was not continuously licensed in another jurisdiction during the period of Minnesota lapse must reapply for licensure under subdivision 4.

Sec. 106. Minnesota Statutes 2016, section 146B.03, subdivision 7, as amended by Laws 2017, chapter 40, article 1, section 34, is amended to read:

Subd. 7. **Temporary licensure.** (a) The commissioner may issue a temporary license to an applicant who submits to the commissioner on a form provided by the commissioner:

(1) proof that the applicant is over the age of 18;

(2) all fees required under section 146B.10; and

(3) a letter from a licensed technician who has agreed to provide the supervision to meet the supervised experience requirement under subdivision 4.

(b) Upon completion of the required supervised experience, the temporary licensee shall submit documentation of satisfactorily completing the requirements under subdivision 4,

and the applicable fee under section 146B.10. The commissioner shall issue a new license in accordance with subdivision 4.

(c) A temporary license issued under this subdivision is valid for one year and may be renewed ~~for one additional year~~ twice.

Sec. 107. Minnesota Statutes 2016, section 146B.07, subdivision 2, is amended to read:

Subd. 2. **Parent or legal guardian consent; prohibitions.** (a) A technician may perform body piercings on an individual under the age of 18 if:

(1) the individual's parent or legal guardian is present;

(2) the individual's parent or legal guardian provides personal identification by using one of the methods described in subdivision 1, paragraph (a), clauses (1) to (5), and provides documentation that reasonably establishes that the individual is the parent or legal guardian of the individual who is seeking the body piercing;

(3) the individual seeking the body piercing provides proof of identification by using one of the methods described in subdivision 1, paragraph (a), clauses (1) to (5), a current student identification, or another official source that includes the name and a photograph of the individual;

(4) a consent form and the authorization form under subdivision 1, paragraph (b) is signed by the parent or legal guardian in the presence of the technician; and

(5) the piercing is not prohibited under paragraph (c).

(b) ~~No technician shall tattoo any~~ Tattooing an individual under the age of 18 is a gross misdemeanor, regardless of parental or guardian consent.

(c) No nipple or genital piercing, branding, scarification, suspension, subdermal implantation, microdermal, or tongue bifurcation shall be performed by any technician on any individual under the age of 18 regardless of parental or guardian consent.

(d) No technician shall perform body art procedures on any individual who appears to be under the influence of alcohol, controlled substances as defined in section 152.01, subdivision 4, or hazardous substances as defined in rules adopted under chapter 182.

(e) No technician shall perform body art procedures while under the influence of alcohol, controlled substances as defined under section 152.01, subdivision 4, or hazardous substances as defined in the rules adopted under chapter 182.

(f) No technician shall administer anesthetic injections or other medications.

Sec. 108. Minnesota Statutes 2016, section 146B.10, subdivision 1, is amended to read:

Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure and biennial licensure renewal is ~~$100~~ $420.

(b) The fee for temporary technician licensure is ~~$100~~ $240.

(c) The fee for the temporary guest artist license is ~~$50~~ $140.

(d) The fee for a dual body art technician license is ~~$100~~ $420.

(e) The fee for a provisional establishment license is ~~$1,000~~ $1,500.

(f) The fee for an initial establishment license and the ~~three-year~~ two-year license renewal period required in section 146B.02, subdivision 2, paragraph (b), is ~~$1,000~~ $1,500.

(g) The fee for a temporary body art establishment event permit is ~~$75~~ $200.

(h) The commissioner shall prorate the initial two-year technician license fee ~~and the initial three-year body art establishment license fee~~ based on the number of months in the initial licensure period. The commissioner shall prorate the first renewal fee for the establishment license based on the number of months from issuance of the provisional license to the first renewal.

(i) The fee for verification of licensure to other states is $25.

(j) The fee to reissue a provisional establishment license that relocates prior to inspection and removal of provisional status is $350. The expiration date of the provisional license does not change.

(k) The fee to change an establishment name or establishment type, such as tattoo, piercing, or dual, is $50.

Sec. 109. Minnesota Statutes 2016, section 146B.10, subdivision 2, is amended to read:

Subd. 2. **~~Penalty for~~ Late ~~renewals~~ renewal fee.** (a) The ~~penalty~~ fee for late submission ~~for~~ of a technician renewal ~~applications~~ application is ~~$75~~ $150.

(b) The fee for late submission of an establishment renewal application is $300.

Sec. 110. Minnesota Statutes 2016, section 146B.10, is amended by adding a subdivision to read:

Subd. 2a. **Technical violation fee for practice after lapse.** (a) The technical violation fee for practicing body art after a body art license has expired and before it is renewed is

$200 for any part of the first month, plus $200 for any part of any subsequent month up to one year. Continued practice or operation after one year becomes a disciplinary violation.

(b) The technical violation fee for practicing body art after a temporary body art license has expired and before it is renewed is $100 for any part of the first month, plus $100 for any part of any subsequent month up to six months. Continued practice or operation after six months becomes a disciplinary violation.

(c) The technical violation fee for operating a body art establishment after the license has expired and before it is renewed is $300 for any part of the first month, plus $300 for any part of any subsequent month up to six months. Continued practice or operation after six months becomes a disciplinary violation.

Sec. 111. Minnesota Statutes 2016, section 148.514, subdivision 1, is amended to read:

Subdivision 1. **General licensure procedures.** An applicant for licensure must:

(1) submit an application as required under section 148.519, subdivision 1; ~~and~~

(2) submit all fees required under section 148.5194.~~;~~ and

(3) consent to a fingerprint-based background check as required under section 148.519.

Sec. 112. Minnesota Statutes 2016, section 148.519, subdivision 1, is amended to read:

Subdivision 1. **Applications for licensure.** (a) An applicant for licensure must:

(1) submit a completed application for licensure on forms provided by the commissioner. The application must include the applicant's name, certification number under chapter 153A, if applicable, business address and telephone number, or home address and telephone number if the applicant practices speech-language pathology or audiology out of the home, and a description of the applicant's education, training, and experience, including previous work history for the five years immediately preceding the date of application. The commissioner may ask the applicant to provide additional information necessary to clarify information submitted in the application; and

(2) submit documentation of the certificate of clinical competence issued by the American Speech-Language-Hearing Association, board certification by the American Board of Audiology, or satisfy the following requirements:

(i) submit a transcript showing the completion of a master's or doctoral degree or its equivalent meeting the requirements of section 148.515, subdivision 2;

(ii) submit documentation of the required hours of supervised clinical training;

(iii) submit documentation of the postgraduate clinical or doctoral clinical experience meeting the requirements of section 148.515, subdivision 4; and

(iv) submit documentation of receiving a qualifying score on an examination meeting the requirements of section 148.515, subdivision 6.

(b) In addition, an applicant must:

(1) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(2) submit with the application all fees required by section 148.5194; ~~and~~

(3) sign a waiver authorizing the commissioner to obtain access to the applicant's records in this or any other state in which the applicant has engaged in the practice of speech-language pathology or audiology~~.~~; and

(4) consent to a fingerprint-based criminal history background check as required under section 144.0572, pay all required fees, and cooperate with all requests for information. An applicant must complete a new criminal history background check if more than one year has elapsed since the applicant last applied for a license.

Sec. 113. Minnesota Statutes 2016, section 148.519, subdivision 2, is amended to read:

Subd. 2. **Action on applications for licensure.** (a) The commissioner shall act on an application for licensure according to paragraphs (b) to ~~(d)~~ (e).

(b) The commissioner shall determine if the applicant meets the requirements for licensure. The commissioner or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The commissioner shall not issue a license to an applicant who refuses to consent to a background study within 90 days after submission of an application or fails to submit fingerprints to the Department of Human Services. Any fees paid by the applicant to the Department of Health shall be forfeited if the applicant refuses to consent to the background study.

~~(c)~~ (d) The commissioner shall notify an applicant, via certified mail, of action taken on the application and of the grounds for denying licensure if licensure is denied.

~~(d)~~ (e) An applicant denied licensure may make a written request to the commissioner, within 30 days of the date of notification to the applicant, for reconsideration of the denial. Individuals requesting reconsideration may submit information that the applicant wants considered in the reconsideration. After reconsideration of the commissioner's determination

to deny licensure, the commissioner shall determine whether the original determination should be affirmed or modified. An applicant may make only one request in any one biennial license period for reconsideration of the commissioner's determination to deny licensure.

Sec. 114. Minnesota Statutes 2016, section 148.5194, subdivision 2, is amended to read:

Subd. 2. **Speech-language pathologist ~~biennial~~ licensure ~~fee~~ fees.** (a) The fee for initial licensure ~~and biennial licensure, clinical fellowship licensure, temporary licensure, or renewal~~ for a speech-language pathologist is ~~$200~~ $210.50.

(b) The fee for clinical fellowship licensure, doctoral externship, temporary license, or renewal for a speech-language pathologist is $200.

Sec. 115. Minnesota Statutes 2016, section 148.5194, subdivision 3, is amended to read:

Subd. 3. **~~Biennial~~ Licensure ~~fee~~ fees for dual licensure as a speech-language pathologist and audiologist.** (a) The fee for initial dual licensure ~~and biennial licensure, clinical fellowship licensure, doctoral externship, temporary license, or renewal~~ as a speech-language pathologist and audiologist is ~~$435~~ $523.

(b) The fee for clinical fellowship licensure, doctoral externship, temporary license, or renewal for dual licensure as a speech-language pathologist and audiologist is $510.

Sec. 116. Minnesota Statutes 2016, section 148.5194, subdivision 4, is amended to read:

Subd. 4. **Penalty fee for late renewals.** The penalty fee for late submission of a renewal application is ~~$45~~ $60.

Sec. 117. Minnesota Statutes 2016, section 148.5194, subdivision 7, is amended to read:

Subd. 7. **Audiologist biennial licensure fee.** ~~(a)~~ The licensure fee for initial applicants is $523. The biennial licensure fee for audiologists for clinical fellowship, doctoral externship, temporary, ~~initial applicants,~~ and renewal ~~licensees~~ licenses is ~~$435~~ $510.

~~(b) The audiologist fee is for practical examination costs greater than audiologist exam fee receipts and for complaint investigation, enforcement action, and consumer information and assistance expenditures related to hearing instrument dispensing.~~

Sec. 118. Minnesota Statutes 2016, section 148.5194, is amended by adding a subdivision to read:

Subd. 7a. **Surcharge.** Speech-language pathologists who were licensed prior to January 1, 2018, shall pay a onetime surcharge of $10.50 to renew when their license first expires after January 1, 2020. Audiologists who were licensed before January 1, 2018, shall pay a onetime surcharge of $13 to renew when their license first expires after January 1, 2020. The surcharge shall cover the commissioner's costs associated with criminal background checks.

Sec. 119. Minnesota Statutes 2016, section 148.5195, subdivision 2, is amended to read:

Subd. 2. **Rights of applicants and licensees.** The rights of an applicant denied licensure are stated in section 148.519, subdivision 2, paragraph ~~(d)~~ (e). A licensee shall not be subjected to disciplinary action under this section without first having an opportunity for a contested case hearing under chapter 14.

Sec. 120. Minnesota Statutes 2016, section 148.997, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) The application fee is ~~$130~~ $185.

(b) The criminal background check fee is ~~$6~~ $15.

Sec. 121. Minnesota Statutes 2016, 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 ~~by December 1, 2014, unless the commissioner obtains an adequate supply of federally sourced medical cannabis by August 1, 2014~~. The commissioner shall register new manufacturers or reregister the existing manufacturers by December 1 every two years, using the factors described in ~~paragraph (e)~~ this subdivision. The commissioner shall ~~continue to~~ accept applications after December 1, 2014, ~~if two manufacturers that meet the qualifications set forth in this subdivision do not apply before 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.

~~(d)~~ (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.

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

Sec. 122. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision to read:

Subd. 1a. **Revocation, nonrenewal, or denial of consent to transfer a medical cannabis manufacturer registration.** If the commissioner intends to revoke, 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.

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

Sec. 123. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision to read:

Subd. 1b. **Temporary suspension proceedings.** The commissioner may institute proceedings to temporarily suspend the registration of a medical cannabis manufacturer for a period of up to 90 days by notifying the manufacturer in writing if any action by an employee, agent, officer, director, or controlling person of the manufacturer:

(1) violates any of the requirements of sections 152.21 to 152.37 or the rules adopted thereunder;

(2) permits, aids, or abets the commission of any violation of state law at the manufacturer's location for cultivation, harvesting, manufacturing, packaging, and processing or at any site for distribution of medical cannabis;

(3) performs any act contrary to the welfare of a registered patient or registered designated caregiver; or

(4) obtains, or attempts to obtain, a registration by fraudulent means or misrepresentation.

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

Sec. 124. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision 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 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 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.

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

Sec. 125. Minnesota Statutes 2016, section 152.28, is amended by adding a subdivision to read:

Subd. 3. **Advertising restrictions.** (a) A health care practitioner shall not publish or cause to be published any advertisement that:

(1) contains false or misleading statements about medical cannabis or about the medical cannabis registry program;

(2) uses colloquial terms to refer to medical cannabis, such as pot, weed, or grass;

(3) states or implies the health care practitioner is endorsed by the Department of Health or by the medical cannabis registry program;

(4) includes images of cannabis in its plant or leaf form or of cannabis-smoking paraphernalia; or

(5) contains medical symbols that could reasonably be confused with symbols of established medical associations or groups.

(b) A health care practitioner found by the commissioner to have violated this subdivision is prohibited from certifying that patients have a qualifying medical condition for purposes of patient participation in the registry program. The commissioner's decision that a health care practitioner has violated this subdivision is a final decision of the commissioner and is not subject to the contested case procedures in chapter 14.

Sec. 126. Minnesota Statutes 2016, section 152.33, is amended by adding a subdivision to read:

Subd. 1a. **Intentional diversion outside the state; penalties.** (a) In addition to any other applicable penalty in law, the commissioner shall levy a fine of $250,000 against a manufacturer and may immediately initiate proceedings to revoke the manufacturer's registration, using the procedure in section 152.25, if:

(1) an officer, director, or controlling person of the manufacturer pleads or is found guilty under subdivision 1 of intentionally transferring medical cannabis, while the person

was an officer, director, or controlling person of the manufacturer, to a person other than allowed by law; and

(2) in intentionally transferring medical cannabis to a person other than allowed by law, the officer, director, or controlling person transported or directed the transport of medical cannabis outside of Minnesota.

(b) All fines collected under this subdivision shall be deposited in the state government special revenue fund.

EFFECTIVE DATE. This section is effective the day following final enactment, and applies to crimes committed on or after that date.

Sec. 127. Minnesota Statutes 2016, section 153A.14, subdivision 1, is amended to read:

Subdivision 1. **Application for certificate.** An applicant must:

(1) be 21 years of age or older;

(2) apply to the commissioner for a certificate to dispense hearing instruments on application forms provided by the commissioner;

(3) at a minimum, provide the applicant's name, Social Security number, business address and phone number, employer, and information about the applicant's education, training, and experience in testing human hearing and fitting hearing instruments;

(4) include with the application a statement that the statements in the application are true and correct to the best of the applicant's knowledge and belief;

(5) include with the application a written and signed authorization that authorizes the commissioner to make inquiries to appropriate regulatory agencies in this or any other state where the applicant has sold hearing instruments;

(6) submit certification to the commissioner that the applicant's audiometric equipment has been calibrated to meet current ANSI standards within 12 months of the date of the application;

(7) submit evidence of continuing education credits, if required; ~~and~~

(8) submit all fees as required under section 153A.17~~.~~; and

(9) consent to a fingerprint-based criminal history records check required under section 144.0572, pay all required fees, and cooperate with all requests for information. An applicant must complete a new criminal background check if more than one year has elapsed since the applicant last applied for a license.

Sec. 128. Minnesota Statutes 2016, section 153A.14, subdivision 2, is amended to read:

Subd. 2. **Issuance of certificate.** (a) The commissioner shall issue a certificate to each dispenser of hearing instruments who applies under subdivision 1 if the commissioner determines that the applicant is in compliance with this chapter, has passed an examination administered by the commissioner, has met the continuing education requirements, if required, and has paid the fee set by the commissioner. The commissioner may reject or deny an application for a certificate if there is evidence of a violation or failure to comply with this chapter.

(b) The commissioner shall not issue a certificate to an applicant who refuses to consent to a criminal history background check as required by section 144.0572 within 90 days after submission of an application or fails to submit fingerprints to the Department of Human Services. Any fees paid by the applicant to the Department of Health shall be forfeited if the applicant refuses to consent to the background study.

Sec. 129. Minnesota Statutes 2016, section 153A.17, is amended to read:

153A.17 EXPENSES; FEES.

(a) The expenses for administering the certification requirements, including the complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15, and the Consumer Information Center under section 153A.18, must be paid from initial application and examination fees, renewal fees, penalties, and fines. The commissioner 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. Surcharges collected by the commissioner of health under section 16E.22 are not subject to this paragraph.

(b) The fees are as follows:

(1) the initial ~~and annual renewal~~ certification application fee is ~~$600~~ $772.50;

(2) ~~the initial examination fee for the written portion is $500, and for each time it is taken, thereafter~~ the annual renewal certification application fee is $750;

(3) the initial examination fee for the practical portion is $1,200, and $600 for each time it is taken, thereafter; for individuals meeting the requirements of section 148.515, subdivision 2, the fee for the practical portion of the hearing instrument dispensing examination is ~~$250~~ $600 each time it is taken;

(4) the trainee application fee is ~~$200~~ $230;

(5) the penalty fee for late submission of a renewal application is ~~$200~~ $260; and

(6) the fee for verification of certification to other jurisdictions or entities is $25.

(c) The commissioner may prorate the certification fee for new applicants based on the number of quarters remaining in the annual certification period.

(d) All fees are nonrefundable. All fees, penalties, and fines received must be deposited in the state government special revenue fund.

(e) ~~Beginning July 1, 2009, until June 30, 2016, a surcharge of $100 shall be paid at the time of initial certification application or renewal to recover the commissioner's accumulated direct expenditures for administering the requirements of this chapter.~~ Hearing instrument dispensers who were certified before January 1, 2018, shall pay a onetime surcharge of $22.50 to renew their certification when it expires after October 31, 2020. The surcharge shall cover the commissioner's costs associated with criminal background checks.

Sec. 130. Minnesota Statutes 2016, section 157.16, subdivision 1, is amended to read:

Subdivision 1. **License required annually.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, youth camp, hotel, motel, lodging establishment, public pool, or resort. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan review approval. Special event food stands are not required to submit plans. Nonprofit organizations operating a special event food stand with multiple locations at an annual one-day event shall be issued only one license. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the food and beverage service establishment, hotel, motel, lodging establishment, public pool, or resort; the name under which the business is to be conducted; and any other information as may be required by the commissioner to complete the application for license. All fees collected under this section shall be deposited in the state government special revenue fund.

Sec. 131. Minnesota Statutes 2016, section 157.16, subdivision 3, is amended to read:

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. Food and beverage service

establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4)~~, and establishments serving alcohol must pay the highest applicable fee under paragraph (d), clause (6) or (7)~~. The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, public pools, and resorts shall pay an annual base fee of ~~$150~~ $165.

(c) A special event food stand shall pay a flat fee of ~~$50~~ $55 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand and a school concession stand, and each hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual fee for each fee category, additional food service, or required additional inspection specified in this paragraph:

(1) ~~Limited food menu selection, $60. "Limited food menu selection"~~ Category 1 establishment, $110. "Category 1 establishment" means a fee category that provides one or more of the following items or is one of the listed establishments or facilities:

(i) serves prepackaged food that ~~receives heat treatment and~~ is served in the package;

(ii) ~~frozen pizza that is heated and served;~~

~~(iii)~~ serves a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

~~(iv)~~ (iii) serves soft drinks, coffee, or nonalcoholic beverages; ~~or~~

~~(v)~~ (iv) provides cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site~~.~~;

(v) a food establishment where the method of food preparation meets the definition of a low-risk establishment in section 157.20; or

(vi) operates as a child care facility licensed under section 245A.03 and Minnesota Rules, chapter 9503.

~~(2) Small establishment, including boarding establishments, $120. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:~~

~~(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;~~

~~(ii) serves dipped ice cream or soft serve frozen desserts;~~

~~(iii) serves breakfast in an owner-occupied bed and breakfast establishment;~~

~~(iv) is a boarding establishment; or~~

~~(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.~~

~~(3) Medium establishment, $310. "Medium establishment"~~ (2) Category 2 establishment, $245. "Category 2 establishment" means ~~a fee category that meets one or more of the following~~ an establishment that is not a Category 1 establishment and is either:

(i) ~~possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;~~ a food establishment where the method of food preparation meets the definition of a medium-risk establishment in section 157.20; or

(ii) ~~possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or~~ an elementary or secondary school as defined in section 120A.05.

~~(iii) is an establishment where food is prepared at one location and served at one or more separate locations.~~

~~Establishments meeting criteria in clause (2), item (v), are not included in this fee category.~~

~~(4) Large establishment, $540. "Large establishment"~~ (3) Category 3 establishment, $385. "Category 3 establishment" means an establishment that is not a Category 1 or Category 2 establishment and is either:

(i) ~~a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation~~ a food establishment where the method of food preparation meets the definition of a high-risk establishment in section 157.20; or

(ii) ~~a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.~~ an establishment where 500 or more meals are prepared per day and served at one or more separate locations.

~~(5)~~ (4) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, ~~$60~~ $85.

~~(6) Beer or wine table service, $60. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.~~

~~(7) Alcoholic beverage service, other than beer or wine table service, $165.~~

~~"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.~~

~~(8)~~ (5) Lodging per sleeping accommodation unit, ~~$10~~ $11, including hotels, motels, lodging establishments, and resorts, up to a maximum of ~~$1,000~~ $1,100. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

~~(9)~~ (6) First public pool, ~~$325~~ $355; each additional public pool, ~~$175~~ $200. "Public pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

~~(10)~~ (7) First spa, ~~$175~~ $200; each additional spa, ~~$100~~ $110. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

~~(11)~~ (8) Private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

~~(12)~~ (9) Additional food service, ~~$150~~ $175. "Additional food service" means a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve beverages or food to the public. Additional food service does not apply to school concession stands.

~~(13)~~ (10) Additional inspection fee, ~~$360~~ $250. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility school lunch programs when required by the Richard B. Russell National School Lunch Act.

(11) HACCP verification, $175. "HACCP verification" means an annual fee category for a business that performs one or more specialized process that requires an HACCP plan as required in chapter 31 and Minnesota Rules, chapter 4626.

(e) A fee for review of construction plans must accompany the initial license application for restaurants, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units. A fee for review of an HACCP plan for specialized processing must be submitted and approved prior to preparing and serving the specialized processed food for human consumption. The ~~fee~~ fees for ~~this~~ construction plan ~~review is~~ reviews and HACCP plan reviews are as follows:

Service Area	**Type**	**Fee**
Food	~~limited food menu~~	~~$275~~
	~~small~~ category 1 establishment	$400
	~~medium~~ category 2 establishment	$450
	~~large~~ category 3 food establishment	$500
		~~$150~~
	additional food service	$250
	HACCP Plan Review	$500
Transient food service	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$350
~~Alcohol~~	~~beer or wine table service~~	~~$150~~
	~~alcohol service from bar~~	~~$250~~
Lodging	less than 25 rooms	$375
	25 to less than 100 rooms	$400
	100 rooms or more	$500
	less than five cabins	$350
	five to less than ten cabins	$400
	ten cabins or more	$450

(f) When existing food and beverage service establishments, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units are extensively remodeled, a fee must be submitted with the remodeling plans. The fee for this construction plan review is as follows:

Service Area	**Type**	**Fee**
Food	~~limited food menu~~	~~$250~~
	~~small~~ category 1 establishment	$300

		~~medium~~ category 2 establishment	$350
		~~large food~~ category 3 establishment	$400
			~~$150~~
		additional food service	$250
	Transient food service	food cart	$250
		seasonal permanent food stand	$250
		seasonal temporary food stand	$250
		mobile food unit	$250
	~~Alcohol~~	~~beer or wine table service~~	~~$150~~
		~~alcohol service from bar~~	~~$250~~
	Lodging	less than 25 rooms	$250
		25 to less than 100 rooms	$300
		100 rooms or more	$450
		less than five cabins	$250
		five to less than ten cabins	$350
		ten cabins or more	$400

(g) Special event food stands are not required to submit construction or remodeling plans for review.

(h) Youth camps shall pay an annual single fee for food and lodging as follows:

(1) camps with up to 99 campers, $325;

(2) camps with 100 to 199 campers, $550; and

(3) camps with 200 or more campers, $750.

(i) A youth camp which pays fees under paragraph (d) is not required to pay fees under paragraph (h).

Sec. 132. Minnesota Statutes 2016, section 157.16, subdivision 3a, is amended to read:

Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a ~~$35~~ $40 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Sec. 133. Minnesota Statutes 2016, section 245C.10, is amended by adding a subdivision to read:

Subd. 2a. **Occupations regulated by commissioner of health.** The commissioner shall set fees to recover the cost of combined background studies and criminal background checks initiated by applicants, licensees, and certified practitioners regulated under sections 148.511 to 148.5198 and chapter 153A. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Sec. 134. Minnesota Statutes 2016, section 327.15, subdivision 3, is amended to read:

Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a) The following fees are required for manufactured home parks and recreational camping areas licensed under this chapter. Fees collected under this section shall be deposited in the state government special revenue fund. Recreational camping areas and manufactured home parks shall pay the highest applicable base fee under paragraph (b). The license fee for new operators of a manufactured home park or recreational camping area previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All manufactured home parks and recreational camping areas shall pay the following annual base fee:

(1) a manufactured home park, ~~$150~~ $165; and

(2) a recreational camping area with:

(i) 24 or less sites, ~~$50~~ $55;

(ii) 25 to 99 sites, ~~$212~~ $230; and

(iii) 100 or more sites, ~~$300~~ $330.

In addition to the base fee, manufactured home parks and recreational camping areas shall pay ~~$4~~ $5 for each licensed site. This paragraph does not apply to special event recreational camping areas. Operators of a manufactured home park or a recreational camping area also licensed under section 157.16 for the same location shall pay only one base fee, whichever is the highest of the base fees found in this section or section 157.16.

(c) In addition to the fee in paragraph (b), each manufactured home park or recreational camping area shall pay an additional annual fee for each fee category specified in this paragraph:

(1) Manufactured home parks and recreational camping areas with public swimming pools and spas shall pay the appropriate fees specified in section 157.16.

(2) Individual private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface sewage treatment system which uses subsurface treatment and disposal.

(d) The following fees must accompany a plan review application for initial construction of a manufactured home park or recreational camping area:

(1) for initial construction of less than 25 sites, $375;

(2) for initial construction of 25 to 99 sites, $400; and

(3) for initial construction of 100 or more sites, $500.

(e) The following fees must accompany a plan review application when an existing manufactured home park or recreational camping area is expanded:

(1) for expansion of less than 25 sites, $250;

(2) for expansion of 25 to 99 sites, $300; and

(3) for expansion of 100 or more sites, $450.

Sec. 135. Minnesota Statutes 2016, section 364.09, is amended to read:

364.09 EXCEPTIONS.

(a) This chapter does not apply to the licensing process for peace officers; to law enforcement agencies as defined in section 626.84, subdivision 1, paragraph (f); to fire protection agencies; to eligibility for a private detective or protective agent license; to the licensing and background study process under chapters 245A and 245C; to the licensing and background investigation process under chapter 240; to eligibility for school bus driver endorsements; to eligibility for special transportation service endorsements; to eligibility for a commercial driver training instructor license, which is governed by section 171.35 and rules adopted under that section; to emergency medical services personnel, or to the licensing by political subdivisions of taxicab drivers, if the applicant for the license has

been discharged from sentence for a conviction within the ten years immediately preceding application of a violation of any of the following:

(1) sections 609.185 to 609.2114, 609.221 to 609.223, 609.342 to 609.3451, or 617.23, subdivision 2 or 3; or Minnesota Statutes 2012, section 609.21;

(2) any provision of chapter 152 that is punishable by a maximum sentence of 15 years or more; or

(3) a violation of chapter 169 or 169A involving driving under the influence, leaving the scene of an accident, or reckless or careless driving.

This chapter also shall not apply to eligibility for juvenile corrections employment, where the offense involved child physical or sexual abuse or criminal sexual conduct.

(b) This chapter does not apply to a school district or to eligibility for a license issued or renewed by the Board of Teaching or the commissioner of education.

(c) Nothing in this section precludes the Minnesota Police and Peace Officers Training Board or the state fire marshal from recommending policies set forth in this chapter to the attorney general for adoption in the attorney general's discretion to apply to law enforcement or fire protection agencies.

(d) This chapter does not apply to a license to practice medicine that has been denied or revoked by the Board of Medical Practice pursuant to section 147.091, subdivision 1a.

(e) This chapter does not apply to any person who has been denied a license to practice chiropractic or whose license to practice chiropractic has been revoked by the board in accordance with section 148.10, subdivision 7.

(f) This chapter does not apply to any license, registration, or permit that has been denied or revoked by the Board of Nursing in accordance with section 148.261, subdivision 1a.

(g) This chapter does not apply to any license, registration, permit, or certificate that has been denied or revoked by the commissioner of health according to section 148.5195, subdivision 5; or 153A.15, subdivision 2.

~~(g)~~ (h) This chapter does not supersede a requirement under law to conduct a criminal history background investigation or consider criminal history records in hiring for particular types of employment.

Sec. 136. Minnesota Statutes 2016, section 609.5315, subdivision 5c, is amended to read:

Subd. 5c. **Disposition of money; prostitution.** Money forfeited under section 609.5312, subdivision 1, paragraph (b), must be distributed as follows:

(1) 40 percent must be forwarded to the appropriate agency for deposit as a supplement to the agency's operating fund or similar fund for use in law enforcement;

(2) 20 percent must be forwarded to the prosecuting authority that handled the forfeiture for deposit as a supplement to its operating fund or similar fund for prosecutorial purposes; and

(3) the remaining 40 percent must be forwarded to the commissioner of ~~public safety~~ health to be deposited in the safe harbor for youth account in the special revenue fund and is appropriated to the commissioner for distribution to crime victims services organizations that provide services to sexually exploited youth, as defined in section 260C.007, subdivision 31.

Sec. 137. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

(b) "Commissioner" means the commissioner of human services.

(c) "Facility" means:

(1) a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 144H or 245D;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

(3) a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

(d) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege sexual abuse or substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(e) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve sexual abuse or substantial child endangerment, and for reports of maltreatment in facilities required to be licensed under chapter 245A or 245D; under sections 144.50 to 144.58 and 241.021; in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E; or in a nonlicensed personal care provider association as defined in section 256B.0625, subdivision 19a.

(f) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

(g) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's

child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(h) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

(i) "Operator" means an operator or agency as defined in section 245A.02.

(j) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(k) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;

(9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(11) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Report" means any communication received by the local welfare agency, police department, county sheriff, or agency responsible for child protection pursuant to this section that describes neglect or physical or sexual abuse of a child and contains sufficient content to identify the child and any person believed to be responsible for the neglect or abuse, if known.

(n) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports of known or suspected child sex trafficking involving a child who is identified as a victim

of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321, subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(o) "Substantial child endangerment" means a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) solicitation, inducement, and promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) solicitation of children to engage in sexual conduct under section 609.352;

(10) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(11) use of a minor in sexual performance under section 617.246; or

(12) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

(p) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (j), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (q) from the Department of Human Services.

(q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (p), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(r) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

Sec. 138. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused

within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 144H or 245D; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision ~~19~~ 19a. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Notification requirements under subdivision 10 apply to all reports received under this section.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

Sec. 139. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The county

local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245D, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

Sec. 140. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 144H or 245D, or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an assessment or investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency

knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian previously notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation. In the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification to parents, guardians, or legal custodians of each child in the facility, but shall, within ten days after the investigation is completed, provide written notification to the parent, guardian, or legal custodian of any student alleged to have been maltreated. The commissioner of education may notify the parent, guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

Sec. 141. **RECOMMENDATIONS FOR SAFETY AND QUALITY IMPROVEMENT PRACTICES FOR LONG-TERM CARE SERVICES AND SUPPORTS.**

The commissioner of health shall consult with interested stakeholders to consider:

(1) systems improvements in processes used by the Office of Health Facility Complaints to investigate reports of maltreatment of vulnerable adults received by the office and processes used to report maltreatment to the office; and

(2) options for implementing prevention strategies, alternative reporting approaches, and proven patient safety and quality improvement practices and infrastructure for long-term care services and supports.

Sec. 142. **STUDY AND REPORT ON HOME CARE NURSING WORKFORCE SHORTAGE.**

(a) The chair and ranking minority member of the senate Human Services Reform Finance and Policy Committee and the chair and ranking minority member of the house of representatives Health and Human Services Finance Committee shall convene a working group to study and report on the shortage of registered nurses and licensed practical nurses available to provide low-complexity regular home care services to clients in need of such services, especially clients covered by medical assistance, and to provide recommendations for ways to address the workforce shortage. The working group shall consist of 14 members appointed as follows:

(1) the chair of the senate Human Services Reform Finance and Policy Committee or a designee;

(2) the ranking minority member of the senate Human Services Reform Finance and Policy Committee or a designee;

(3) the chair of the house of representatives Health and Human Services Finance Committee or a designee;

(4) the ranking minority member of the house of representatives Health and Human Services Finance Committee or a designee;

(5) the commissioner of human services or a designee;

(6) the commissioner of health or a designee;

(7) one representative appointed by the Professional Home Care Coalition;

(8) one representative appointed by the Minnesota Home Care Association;

(9) one representative appointed by the Minnesota Board of Nursing;

(10) one representative appointed by the Minnesota Nurses Association;

(11) one representative appointed by the Minnesota Licensed Practical Nurses Association;

(12) one representative appointed by the Minnesota Society of Medical Assistants;

(13) one client who receives regular home care nursing services and is covered by medical assistance appointed by the commissioner of human services after consulting with the appointing authorities identified in clauses (7) to (12); and

(14) one assessor appointed by the commissioner of human services. The assessor must be certified under Minnesota Statutes, section 256B.0911, and must be a registered nurse.

(b) The appointing authorities must appoint members by August 1, 2017.

(c) The convening authorities shall convene the first meeting of the working group no later than August 15, 2017, and caucus staff shall provide support and meeting space for the working group. The Department of Health and the Department of Human Services shall provide technical assistance to the working group by providing existing data and analysis documenting the current and projected workforce shortages in the area of regular home care nursing. The home care and assisted living program advisory council established under Minnesota Statutes, section 144A.4799, shall provide advice and recommendations to the working group. Working group members shall serve without compensation and shall not be reimbursed for expenses.

(d) The working group shall:

(1) quantify the number of low-complexity regular home care nursing hours that are authorized but not provided to clients covered by medical assistance, due to the shortage of registered nurses and licensed practical nurses available to provide these home care services;

(2) quantify the current and projected workforce shortages of registered nurses and licensed practical nurses available to provide low-complexity regular home care nursing services to clients, especially clients covered by medical assistance;

(3) develop recommendations for actions to take in the next two years to address the regular home care nursing workforce shortage, including identifying other health care professionals who may be able to provide low-complexity regular home care nursing services

with additional training; what additional training may be necessary for these health care professionals; and how to address scope of practice and licensing issues;

(4) compile reimbursement rates for regular home care nursing from other states and determine Minnesota's national ranking with respect to reimbursement for regular home care nursing;

(5) determine whether reimbursement rates for regular home care nursing fully reimburse providers for the cost of providing the service and whether the discrepancy, if any, between rates and costs contributes to lack of access to regular home care nursing; and

(6) by January 15, 2018, report on the findings and recommendations of the working group to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The working group's report shall include draft legislation.

(e) The working group shall elect a chair from among its members at its first meeting.

(f) The meetings of the working group shall be open to the public.

(g) This section expires January 16, 2018, or the day after submitting the report required by this section, whichever is earlier.

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

Sec. 143. **OPIOID ABUSE PREVENTION PILOT PROJECTS.**

(a) The commissioner of health shall establish opioid abuse prevention pilot projects in geographic areas throughout the state based on the most recently available data on opioid overdose and abuse rates, to reduce opioid abuse through the use of controlled substance care teams and community-wide coordination of abuse-prevention initiatives. The commissioner shall award grants to health care providers, health plan companies, local units of government, tribal governments, or other entities to establish pilot projects.

(b) Each pilot project must:

(1) be designed to reduce emergency room and other health care provider visits resulting from opioid use or abuse, and reduce rates of opioid addiction in the community;

(2) establish multidisciplinary controlled substance care teams, that may consist of physicians, pharmacists, social workers, nurse care coordinators, and mental health professionals;

(3) deliver health care services and care coordination, through controlled substance care teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

(4) address any unmet social service needs that create barriers to managing pain effectively and obtaining optimal health outcomes;

(5) provide prescriber and dispenser education and assistance to reduce the inappropriate prescribing and dispensing of opioids;

(6) promote the adoption of best practices related to opioid disposal and reducing opportunities for illegal access to opioids; and

(7) engage partners outside of the health care system, including schools, law enforcement, and social services, to address root causes of opioid abuse and addiction at the community level.

(c) The commissioner shall contract with an accountable community for health that operates an opioid abuse prevention project, and can document success in reducing opioid use through the use of controlled substance care teams, to assist the commissioner in administering this section, and to provide technical assistance to the commissioner and to entities selected to operate a pilot project.

(d) The contract under paragraph (c) shall require the accountable community for health to evaluate the extent to which the pilot projects were successful in reducing the inappropriate use of opioids. The evaluation must analyze changes in the number of opioid prescriptions, the number of emergency room visits related to opioid use, and other relevant measures. The accountable community for health shall report evaluation results to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and public safety by December 15, 2019.

(e) The commissioner may award one grant that, in addition to the other requirements of this section, allows a root cause approach to reduce opioid abuse in an American Indian community.

Sec. 144. **SAFE HARBOR FOR ALL; STATEWIDE SEX TRAFFICKING VICTIMS STRATEGIC PLAN.**

(a) By October 1, 2018, the commissioner of health, in consultation with the commissioners of public safety and human services, shall adopt a comprehensive strategic plan to address the needs of sex trafficking victims statewide.

(b) The commissioner of health shall issue a request for proposals to select an organization to develop the comprehensive strategic plan. The selected organization shall seek recommendations from professionals, community members, and stakeholders from across the state, with an emphasis on the communities most impacted by sex trafficking. At a minimum, the selected organization must seek input from the following groups: sex trafficking survivors and their family members, statewide crime victim services coalitions, victim services providers, nonprofit organizations, task forces, prosecutors, public defenders, tribal governments, public safety and corrections professionals, public health professionals, human services professionals, and impacted community members. The strategic plan shall include recommendations regarding the expansion of Minnesota's Safe Harbor Law to adult victims of sex trafficking.

(c) By January 15, 2019, the commissioner of health shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and criminal justice finance and policy on developing the statewide strategic plan, including recommendations for additional legislation and funding.

(d) As used in this section, "sex trafficking victim" has the meaning given in Minnesota Statutes, section 609.321, subdivision 7b.

Sec. 145. **DIRECTION TO THE COMMISSIONER OF HEALTH.**

The commissioner of health shall work with interested stakeholders to evaluate whether existing laws, including laws governing housing with services establishments, board and lodging establishments with special services, assisted living designations, and home care providers, as well as building code requirements and landlord tenancy laws, sufficiently protect the health and safety of persons diagnosed with Alzheimer's disease or a related dementia.

Sec. 146. **PALLIATIVE CARE ADVISORY COUNCIL.**

The appointing authorities shall appoint the first members of the Palliative Care Advisory Council under Minnesota Statutes, section 144.059, by October 1, 2017. The commissioner of health shall convene the first meeting by November 15, 2017, and the commissioner or the commissioner's designee shall act as chair until the council elects a chair at its first meeting.

Sec. 147. **REPEALER.**

Minnesota Statutes 2016, sections 103I.005, subdivisions 8, 14, and 15; 103I.451; and 144.0571, are repealed.

ARTICLE 11

HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2016, section 147.01, subdivision 7, is amended to read:

Subd. 7. **Physician application ~~fee~~ and license fees.** (a) The board may charge ~~a~~ the following nonrefundable application and license fees processed pursuant to sections 147.02, 147.03, 147.037, 147.0375, and 147.38:

(1) physician application fee ~~of~~, $200~~.~~;

(2) physician annual registration renewal fee, $192;

(3) physician endorsement to other states, $40;

(4) physician emeritus license, $50;

(5) physician temporary licenses, $60;

(6) physician late fee, $60;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) education or training program approval fee, $100;

(10) report creation and generation fee, $60;

(11) examination administration fee (half day), $50;

(12) examination administration fee (full day), $80; and

(13) fees developed by the Interstate Commission for determining physician qualification to register and participate in the interstate medical licensure compact, as established in rules authorized in and pursuant to section 147.38, not to exceed $1,000.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

Sec. 2. Minnesota Statutes 2016, section 147.02, subdivision 1, is amended to read:

Subdivision 1. **United States or Canadian medical school graduates.** The board shall issue a license to practice medicine to a person not currently licensed in another state or Canada and who meets the requirements in paragraphs (a) to (i).

(a) An applicant for a license shall file a written application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a medical or osteopathic medical school located in the United States, its territories or Canada, and approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant data, or is currently enrolled in the final year of study at the school.

(c) The applicant must have passed an examination as described in clause (1) or (2).

(1) The applicant must have passed a comprehensive examination for initial licensure prepared and graded by the National Board of Medical Examiners, the Federation of State Medical Boards, the Medical Council of Canada, the National Board of Osteopathic Examiners, or the appropriate state board that the board determines acceptable. The board shall by rule determine what constitutes a passing score in the examination.

(2) The applicant taking the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must have passed steps or levels one, two, and three. Step or level three must be passed within five years of passing step or level two, or before the end of residency training. The applicant must pass each of steps or levels one, two, and three with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts. The applicant taking combinations of Federation of State Medical Boards, National Board of Medical Examiners, and USMLE may be accepted only if the combination is approved by the board as comparable to existing comparable examination sequences and all examinations are completed prior to the year 2000.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program 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.

(e) The applicant may make arrangements with the executive director to appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation.

(f) The applicant shall pay a nonrefundable fee established by the board ~~by rule~~. ~~The fee may not be refunded.~~ Upon application or notice of license renewal, the board must provide notice to the applicant and to the person whose license is scheduled to be issued or renewed of any additional fees, surcharges, or other costs which the person is obligated to pay as a condition of licensure. The notice must:

(1) state the dollar amount of the additional costs; and

(2) clearly identify to the applicant the payment schedule of additional costs.

(g) 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.

(h) 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 (g). If the 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 and limitations the board considers appropriate.

(i) If the examination in paragraph (c) was passed more than ten years ago, the applicant must either:

(1) pass the special purpose examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(2) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

Sec. 3. Minnesota Statutes 2016, section 147.03, subdivision 1, is amended to read:

Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice medicine to any person who satisfies the requirements in paragraphs (b) to ~~(f)~~(e).

(b) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (b), (d), (e), and (f).

(c) The applicant shall:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the National Board of Medical Examiners, or the United States Medical Licensing Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council of Canada; and

(2) have a current license from the equivalent licensing agency in another state or Canada 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, 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 Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

~~(d) The applicant shall pay a fee established by the board by rule. The fee may not be refunded.~~

~~(e)~~ (d) 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.

~~(f)~~ (e) 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 ~~(e)~~ (d). 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.

~~(g)~~ (f) Upon the request of an applicant, the board may conduct the final interview of the applicant by teleconference.

Sec. 4. **[147A.28] PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.**

(a) The board may charge the following nonrefundable fees:

(1) physician assistant application fee, $120;

(2) physician assistant annual registration renewal fee (prescribing authority), $135;

(3) physician assistant annual registration renewal fee (no prescribing authority), $115;

(4) physician assistant temporary registration, $115;

(5) physician assistant temporary permit, $60;

(6) physician assistant locum tenens permit, $25;

(7) physician assistant late fee, $50;

(8) duplicate license fee, $20;

(9) certification letter fee, $25;

(10) education or training program approval fee, $100; and

(11) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 5. Minnesota Statutes 2016, section 147B.08, is amended by adding a subdivision to read:

Subd. 4. **Acupuncturist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) acupuncturist application fee, $150;

(2) acupuncturist annual registration renewal fee, $150;

(3) acupuncturist temporary registration fee, $60;

(4) acupuncturist inactive status fee, $50;

(5) acupuncturist late fee, $50;

(6) duplicate license fee, $20;

(7) certification letter fee, $25;

(8) education or training program approval fee, $100; and

(9) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 6. Minnesota Statutes 2016, section 147C.40, is amended by adding a subdivision to read:

Subd. 5. **Respiratory therapist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) respiratory therapist application fee, $100;

(2) respiratory therapist annual registration renewal fee, $90;

(3) respiratory therapist inactive status fee, $50;

(4) respiratory therapist temporary registration fee, $90;

(5) respiratory therapist temporary permit, $60;

(6) respiratory therapist late fee, $50;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) education or training program approval fee, $100; and

(10) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 7. Minnesota Statutes 2016, section 148.6402, subdivision 4, is amended to read:

Subd. 4. ~~**Commissioner**~~ **Board.** "~~Commissioner~~ Board" means the ~~commissioner of health or a designee~~ Board of Occupational Therapy Practice established in section 148.6449.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 8. Minnesota Statutes 2016, section 148.6405, is amended to read:

148.6405 LICENSURE APPLICATION REQUIREMENTS: PROCEDURES AND QUALIFICATIONS.

(a) An applicant for licensure must comply with the application requirements in section 148.6420. To qualify for licensure, an applicant must satisfy one of the requirements in paragraphs (b) to (f) and not be subject to denial of licensure under section 148.6448.

(b) A person who applies for licensure as an occupational therapist and who has not been credentialed by the National Board for Certification in Occupational Therapy or another jurisdiction must meet the requirements in section 148.6408.

(c) A person who applies for licensure as an occupational therapy assistant and who has not been credentialed by the National Board for Certification in Occupational Therapy or another jurisdiction must meet the requirements in section 148.6410.

(d) A person who is certified by the National Board for Certification in Occupational Therapy may apply for licensure by equivalency and must meet the requirements in section 148.6412.

(e) A person who is credentialed in another jurisdiction may apply for licensure by reciprocity and must meet the requirements in section 148.6415.

(f) A person who applies for temporary licensure must meet the requirements in section 148.6418.

(g) A person who applies for licensure under paragraph (b), (c), or (f) more than two and less than four years after meeting the requirements in section 148.6408 or 148.6410 must submit the following:

(1) a completed and signed application for licensure on forms provided by the ~~commissioner~~ board;

(2) the license application fee required under section 148.6445;

(3) if applying for occupational therapist licensure, proof of having met a minimum of 24 contact hours of continuing education in the two years preceding licensure application, or if applying for occupational therapy assistant licensure, proof of having met a minimum of 18 contact hours of continuing education in the two years preceding licensure application;

(4) verified documentation of successful completion of 160 hours of supervised practice approved by the ~~commissioner~~ board under a limited license specified in section 148.6425, subdivision 3, paragraph (c); and

(5) additional information as requested by the ~~commissioner~~ board to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action under section 148.6448. The information must be submitted within 30 days after the ~~commissioner's~~ board's request.

(h) A person who applied for licensure under paragraph (b), (c), or (f) four years or more after meeting the requirements in section 148.6408 or 148.6410 must meet all the requirements in paragraph (g) except clauses (3) and (4), submit documentation of having retaken and passed the credentialing examination for occupational therapist or occupational therapy assistant, or of having completed an occupational therapy refresher program that contains both a theoretical and clinical component approved by the ~~commissioner~~ board, and verified documentation of successful completion of 480 hours of supervised practice approved by the ~~commissioner~~ board under a limited license specified in section 148.6425, subdivision 3, paragraph (c). The 480 hours of supervised practice must be completed in six months and may be completed at the applicant's place of work. Only refresher courses completed within one year prior to the date of application qualify for approval.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 9. Minnesota Statutes 2016, section 148.6408, subdivision 2, is amended to read:

Subd. 2. **Qualifying examination score required.** (a) An applicant must achieve a qualifying score on the credentialing examination for occupational therapist.

(b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing examination for occupational therapist. In determining the qualifying score, the ~~commissioner~~ board shall consider the cut score recommended by the National Board for Certification in Occupational Therapy, or other national credentialing organization approved by the ~~commissioner~~ board, using the modified Angoff method for determining cut score or another method for determining cut score that is recognized as appropriate and acceptable by industry standards.

(c) The applicant is responsible for:

(1) making arrangements to take the credentialing examination for occupational therapist;

(2) bearing all expenses associated with taking the examination; and

(3) having the examination scores sent directly to the ~~commissioner~~ board from the testing service that administers the examination.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 10. Minnesota Statutes 2016, section 148.6410, subdivision 2, is amended to read:

Subd. 2. **Qualifying examination score required.** (a) An applicant for licensure must achieve a qualifying score on the credentialing examination for occupational therapy assistants.

(b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing examination for occupational therapy assistants. In determining the qualifying score, the ~~commissioner~~ board shall consider the cut score recommended by the National Board for Certification in Occupational Therapy, or other national credentialing organization approved by the ~~commissioner~~ board, using the modified Angoff method for determining cut score or another method for determining cut score that is recognized as appropriate and acceptable by industry standards.

(c) The applicant is responsible for:

(1) making all arrangements to take the credentialing examination for occupational therapy assistants;

(2) bearing all expense associated with taking the examination; and

(3) having the examination scores sent directly to the ~~commissioner~~ board from the testing service that administers the examination.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 11. Minnesota Statutes 2016, section 148.6412, subdivision 2, is amended to read:

Subd. 2. **Persons certified by National Board for Certification in Occupational Therapy after June 17, 1996.** The ~~commissioner~~ board may license any person certified by the National Board for Certification in Occupational Therapy as an occupational therapist after June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification are equivalent to or exceed the requirements for licensure as an occupational therapist under section 148.6408. The ~~commissioner~~ board may license any person certified by the National Board for Certification in Occupational Therapy as an occupational therapy assistant after June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification are equivalent to or exceed the requirements for licensure as an occupational therapy assistant under section 148.6410. Nothing in this section limits the ~~commissioner's~~ board's authority to deny licensure based upon the grounds for discipline in sections 148.6401 to ~~148.6450~~ 148.6449.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 12. Minnesota Statutes 2016, section 148.6415, is amended to read:

148.6415 LICENSURE BY RECIPROCITY.

A person who holds a current credential as an occupational therapist in the District of Columbia or a state or territory of the United States whose standards for credentialing are determined by the ~~commissioner~~ board to be equivalent to or exceed the requirements for licensure under section 148.6408 may be eligible for licensure by reciprocity as an occupational therapist. A person who holds a current credential as an occupational therapy assistant in the District of Columbia or a state or territory of the United States whose standards for credentialing are determined by the ~~commissioner~~ board to be equivalent to or exceed the requirements for licensure under section 148.6410 may be eligible for licensure by reciprocity as an occupational therapy assistant. Nothing in this section limits the ~~commissioner's~~ board's authority to deny licensure based upon the grounds for discipline in sections 148.6401 to ~~148.6450~~ 148.6449. An applicant must provide:

(1) the application materials as required by section 148.6420, subdivisions 1, 3, and 4;

(2) the fees required by section 148.6445;

(3) a copy of a current and unrestricted credential for the practice of occupational therapy as either an occupational therapist or occupational therapy assistant;

(4) a letter from the jurisdiction that issued the credential describing the applicant's qualifications that entitled the applicant to receive the credential; and

(5) other information necessary to determine whether the credentialing standards of the jurisdiction that issued the credential are equivalent to or exceed the requirements for licensure under sections 148.6401 to ~~148.6450~~ 148.6449.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 13. Minnesota Statutes 2016, section 148.6418, subdivision 1, is amended to read:

Subdivision 1. **Application.** The ~~commissioner~~ board shall issue temporary licensure as an occupational therapist or occupational therapy assistant to applicants who are not the subject of a disciplinary action or past disciplinary action, nor disqualified on the basis of items listed in section 148.6448, subdivision 1.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 14. Minnesota Statutes 2016, section 148.6418, subdivision 2, is amended to read:

Subd. 2. **Procedures.** To be eligible for temporary licensure, an applicant must submit a completed application for temporary licensure on forms provided by the ~~commissioner~~ board, the fees required by section 148.6445, and one of the following:

(1) evidence of successful completion of the requirements in section 148.6408, subdivision 1, or 148.6410, subdivision 1;

(2) a copy of a current and unrestricted credential for the practice of occupational therapy as either an occupational therapist or occupational therapy assistant in another jurisdiction; or

(3) a copy of a current and unrestricted certificate from the National Board for Certification in Occupational Therapy stating that the applicant is certified as an occupational therapist or occupational therapy assistant.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 15. Minnesota Statutes 2016, section 148.6418, subdivision 4, is amended to read:

Subd. 4. **Supervision required.** An applicant who has graduated from an accredited occupational therapy program, as required by section 148.6408, subdivision 1, or 148.6410, subdivision 1, and who has not passed the examination required by section 148.6408, subdivision 2, or 148.6410, subdivision 2, must practice under the supervision of a licensed occupational therapist. The supervising therapist must, at a minimum, supervise the person working under temporary licensure in the performance of the initial evaluation, determination of the appropriate treatment plan, and periodic review and modification of the treatment plan. The supervising therapist must observe the person working under temporary licensure in order to assure service competency in carrying out evaluation, treatment planning, and treatment implementation. The frequency of face-to-face collaboration between the person working under temporary licensure and the supervising therapist must be based on the condition of each patient or client, the complexity of treatment and evaluation procedures, and the proficiencies of the person practicing under temporary licensure. The occupational therapist or occupational therapy assistant working under temporary licensure must provide verification of supervision on the application form provided by the ~~commissioner~~ board.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 16. Minnesota Statutes 2016, section 148.6418, subdivision 5, is amended to read:

Subd. 5. **Expiration of temporary licensure.** A temporary license issued to a person pursuant to subdivision 2, clause (1), expires six months from the date of issuance for occupational therapists and occupational therapy assistants or on the date the ~~commissioner~~ board grants or denies licensure, whichever occurs first. A temporary license issued to a person pursuant to subdivision 2, clause (2) or (3), expires 90 days after it is issued. Upon application for renewal, a temporary license shall be renewed once to persons who have not met the examination requirement under section 148.6408, subdivision 2, or 148.6410, subdivision 2, within the initial temporary licensure period and who are not the subject of a disciplinary action nor disqualified on the basis of items in section 148.6448, subdivision 1. Upon application for renewal, a temporary license shall be renewed once to persons who are able to demonstrate good cause for failure to meet the requirements for licensure under section 148.6412 or 148.6415 within the initial temporary licensure period and who are not the subject of a disciplinary action nor disqualified on the basis of items in section 148.6448, subdivision 1.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 17. Minnesota Statutes 2016, section 148.6420, subdivision 1, is amended to read:

Subdivision 1. **Applications for licensure.** An applicant for licensure must:

(1) submit a completed application for licensure on forms provided by the ~~commissioner~~ board and must supply the information requested on the application, including:

(i) the applicant's name, business address and business telephone number, business setting, and daytime telephone number;

(ii) the name and location of the occupational therapy program the applicant completed;

(iii) a description of the applicant's education and training, including a list of degrees received from educational institutions;

(iv) the applicant's work history for the six years preceding the application, including the number of hours worked;

(v) a list of all credentials currently and previously held in Minnesota and other jurisdictions;

(vi) a description of any jurisdiction's refusal to credential the applicant;

(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction;

(viii) information on any physical or mental condition or chemical dependency that impairs the person's ability to engage in the practice of occupational therapy with reasonable judgment or safety;

(ix) a description of any misdemeanor or felony conviction that relates to honesty or to the practice of occupational therapy;

(x) a description of any state or federal court order, including a conciliation court judgment or a disciplinary order, related to the individual's occupational therapy practice; and

(xi) a statement indicating the physical agent modalities the applicant will use and whether the applicant will use the modalities as an occupational therapist or an occupational therapy assistant under direct supervision;

(2) submit with the application all fees required by section 148.6445;

(3) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(4) sign a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's records in this or any other state in which the applicant holds or previously held a credential for the practice of an occupation, has completed an accredited occupational therapy education program, or engaged in the practice of occupational therapy;

(5) submit additional information as requested by the ~~commissioner~~ board; and

(6) submit the additional information required for licensure by equivalency, licensure by reciprocity, and temporary licensure as specified in sections 148.6408 to 148.6418.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 18. Minnesota Statutes 2016, section 148.6420, subdivision 3, is amended to read:

Subd. 3. **Applicants certified by National Board for Certification in Occupational Therapy.** An applicant who is certified by the National Board for Certification in Occupational Therapy must provide the materials required in subdivision 1 and the following:

(1) verified documentation from the National Board for Certification in Occupational Therapy stating that the applicant is certified as an occupational therapist, registered or certified occupational therapy assistant, the date certification was granted, and the applicant's certification number. The document must also include a statement regarding disciplinary actions. The applicant is responsible for obtaining this documentation by sending a form

provided by the ~~commissioner~~ board to the National Board for Certification in Occupational Therapy; and

(2) a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's records maintained by the National Board for Certification in Occupational Therapy.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 19. Minnesota Statutes 2016, section 148.6420, subdivision 5, is amended to read:

Subd. 5. **Action on applications for licensure.** (a) The ~~commissioner~~ board shall approve, approve with conditions, or deny licensure. The ~~commissioner~~ board shall act on an application for licensure according to paragraphs (b) to (d).

(b) The ~~commissioner~~ board shall determine if the applicant meets the requirements for licensure. The ~~commissioner~~ board, or the advisory council at the ~~commissioner's~~ board's request, may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The ~~commissioner~~ board shall notify an applicant of action taken on the application and, if licensure is denied or approved with conditions, the grounds for the ~~commissioner's~~ board's determination.

(d) An applicant denied licensure or granted licensure with conditions may make a written request to the ~~commissioner~~ board, within 30 days of the date of the ~~commissioner's~~ board's determination, for reconsideration of the ~~commissioner's~~ board's determination. Individuals requesting reconsideration may submit information which the applicant wants considered in the reconsideration. After reconsideration of the ~~commissioner's~~ board's determination to deny licensure or grant licensure with conditions, the ~~commissioner~~ board shall determine whether the original determination should be affirmed or modified. An applicant is allowed no more than one request in any one biennial licensure period for reconsideration of the ~~commissioner's~~ board's determination to deny licensure or approve licensure with conditions.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 20. Minnesota Statutes 2016, section 148.6423, is amended to read:

148.6423 LICENSURE RENEWAL.

Subdivision 1. **Renewal requirements.** To be eligible for licensure renewal, a licensee must:

(1) submit a completed and signed application for licensure renewal on forms provided by the ~~commissioner~~ board;

(2) submit the renewal fee required under section 148.6445;

(3) submit proof of having met the continuing education requirement of section 148.6443 on forms provided by the ~~commissioner~~ board; and

(4) submit additional information as requested by the ~~commissioner~~ board to clarify information presented in the renewal application. The information must be submitted within 30 days after the ~~commissioner's~~ board's request.

Subd. 2. **Renewal deadline.** (a) Except as provided in paragraph (c), licenses must be renewed every two years. Licensees must comply with the following procedures in paragraphs (b) to (e):

(b) Each license must state an expiration date. An application for licensure renewal must be received by the ~~Department of Health~~ board or postmarked at least 30 calendar days before the expiration date. If the postmark is illegible, the application shall be considered timely if received at least 21 calendar days before the expiration date.

(c) If the ~~commissioner~~ board changes the renewal schedule and the expiration date is less than two years, the fee and the continuing education contact hours to be reported at the next renewal must be prorated.

(d) An application for licensure renewal not received within the time required under paragraph (b), but received on or before the expiration date, must be accompanied by a late fee in addition to the renewal fee specified by section 148.6445.

(e) Licensure renewals received after the expiration date shall not be accepted and persons seeking licensed status must comply with the requirements of section 148.6425.

Subd. 3. **Licensure renewal notice.** At least 60 calendar days before the expiration date in subdivision 2, the ~~commissioner~~ board shall mail a renewal notice to the licensee's last known address on file with the ~~commissioner~~ board. The notice must include an application for licensure renewal and notice of fees required for renewal. The licensee's failure to receive notice does not relieve the licensee of the obligation to meet the renewal deadline and other requirements for licensure renewal.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 21. Minnesota Statutes 2016, section 148.6425, subdivision 2, is amended to read:

Subd. 2. **Licensure renewal after licensure expiration date.** An individual whose application for licensure renewal is received after the licensure expiration date must submit the following:

(1) a completed and signed application for licensure following lapse in licensed status on forms provided by the ~~commissioner~~ board;

(2) the renewal fee and the late fee required under section 148.6445;

(3) proof of having met the continuing education requirements in section 148.6443, subdivision 1; and

(4) additional information as requested by the ~~commissioner~~ board to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action as set forth in section 148.6448. The information must be submitted within 30 days after the ~~commissioner's~~ board's request.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 22. Minnesota Statutes 2016, section 148.6425, subdivision 3, is amended to read:

Subd. 3. **Licensure renewal four years or more after licensure expiration date.** (a) An individual who requests licensure renewal four years or more after the licensure expiration date must submit the following:

(1) a completed and signed application for licensure on forms provided by the ~~commissioner~~ board;

(2) the renewal fee and the late fee required under section 148.6445 if renewal application is based on paragraph (b), clause (1), (2), or (3), or the renewal fee required under section 148.6445 if renewal application is based on paragraph (b), clause (4);

(3) proof of having met the continuing education requirement in section 148.6443, subdivision 1, except the continuing education must be obtained in the two years immediately preceding application renewal; and

(4) at the time of the next licensure renewal, proof of having met the continuing education requirement, which shall be prorated based on the number of months licensed during the two-year licensure period.

(b) In addition to the requirements in paragraph (a), the applicant must submit proof of one of the following:

(1) verified documentation of successful completion of 160 hours of supervised practice approved by the ~~commissioner~~ board as described in paragraph (c);

(2) verified documentation of having achieved a qualifying score on the credentialing examination for occupational therapists or the credentialing examination for occupational therapy assistants administered within the past year;

(3) documentation of having completed a combination of occupational therapy courses or an occupational therapy refresher program that contains both a theoretical and clinical component approved by the ~~commissioner~~ board. Only courses completed within one year preceding the date of the application or one year after the date of the application qualify for approval; or

(4) evidence that the applicant holds a current and unrestricted credential for the practice of occupational therapy in another jurisdiction and that the applicant's credential from that jurisdiction has been held in good standing during the period of lapse.

(c) To participate in a supervised practice as described in paragraph (b), clause (1), the applicant shall obtain limited licensure. To apply for limited licensure, the applicant shall submit the completed limited licensure application, fees, and agreement for supervision of an occupational therapist or occupational therapy assistant practicing under limited licensure signed by the supervising therapist and the applicant. The supervising occupational therapist shall state the proposed level of supervision on the supervision agreement form provided by the ~~commissioner~~ board. The supervising therapist shall determine the frequency and manner of supervision based on the condition of the patient or client, the complexity of the procedure, and the proficiencies of the supervised occupational therapist. At a minimum, a supervising occupational therapist shall be on the premises at all times that the person practicing under limited licensure is working; be in the room ten percent of the hours worked each week by the person practicing under limited licensure; and provide daily face-to-face collaboration for the purpose of observing service competency of the occupational therapist or occupational therapy assistant, discussing treatment procedures and each client's response to treatment, and reviewing and modifying, as necessary, each treatment plan. The supervising therapist shall document the supervision provided. The occupational therapist participating in a supervised practice is responsible for obtaining the supervision required under this paragraph and must comply with the ~~commissioner's~~ board's requirements for supervision during the entire 160 hours of supervised practice. The supervised practice must be completed in two months and may be completed at the applicant's place of work.

(d) In addition to the requirements in paragraphs (a) and (b), the applicant must submit additional information as requested by the ~~commissioner~~ board to clarify information in the application, including information to determine whether the applicant has engaged in conduct warranting disciplinary action as set forth in section 148.6448. The information must be submitted within 30 days after the ~~commissioner's~~ board's request.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 23. Minnesota Statutes 2016, section 148.6428, is amended to read:

148.6428 CHANGE OF NAME, ADDRESS, OR EMPLOYMENT.

A licensee who changes a name, address, or employment must inform the ~~commissioner~~ board, in writing, of the change of name, address, employment, business address, or business telephone number within 30 days. A change in name must be accompanied by a copy of a marriage certificate or court order. All notices or other correspondence mailed to or served on a licensee by the ~~commissioner~~ board at the licensee's address on file with the ~~commissioner~~ board shall be considered as having been received by the licensee.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 24. Minnesota Statutes 2016, section 148.6443, subdivision 5, is amended to read:

Subd. 5. **Reporting continuing education contact hours.** Within one month following licensure expiration, each licensee shall submit verification that the licensee has met the continuing education requirements of this section on the continuing education report form provided by the ~~commissioner~~ board. The continuing education report form may require the following information:

(1) title of continuing education activity;

(2) brief description of the continuing education activity;

(3) sponsor, presenter, or author;

(4) location and attendance dates;

(5) number of contact hours; and

(6) licensee's notarized affirmation that the information is true and correct.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 25. Minnesota Statutes 2016, section 148.6443, subdivision 6, is amended to read:

Subd. 6. **Auditing continuing education reports.** (a) The ~~commissioner~~ board may audit a percentage of the continuing education reports based on random selection. A licensee shall maintain all documentation required by this section for two years after the last day of the biennial licensure period in which the contact hours were earned.

(b) All renewal applications that are received after the expiration date may be subject to a continuing education report audit.

(c) Any licensee against whom a complaint is filed may be subject to a continuing education report audit.

(d) The licensee shall make the following information available to the ~~commissioner~~ board for auditing purposes:

(1) a copy of the completed continuing education report form for the continuing education reporting period that is the subject of the audit including all supporting documentation required by subdivision 5;

(2) a description of the continuing education activity prepared by the presenter or sponsor that includes the course title or subject matter, date, place, number of program contact hours, presenters, and sponsors;

(3) documentation of self-study programs by materials prepared by the presenter or sponsor that includes the course title, course description, name of sponsor or author, and the number of hours required to complete the program;

(4) documentation of university, college, or vocational school courses by a course syllabus, listing in a course bulletin, or equivalent documentation that includes the course title, instructor's name, course dates, number of contact hours, and course content, objectives, or goals; and

(5) verification of attendance by:

(i) a signature of the presenter or a designee at the continuing education activity on the continuing education report form or a certificate of attendance with the course name, course date, and licensee's name;

(ii) a summary or outline of the educational content of an audio or video educational activity to verify the licensee's participation in the activity if a designee is not available to sign the continuing education report form;

(iii) verification of self-study programs by a certificate of completion or other documentation indicating that the individual has demonstrated knowledge and has successfully completed the program; or

(iv) verification of attendance at a university, college, or vocational course by an official transcript.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 26. Minnesota Statutes 2016, section 148.6443, subdivision 7, is amended to read:

Subd. 7. **Waiver of continuing education requirements.** The ~~commissioner~~ board may grant a waiver of the requirements of this section in cases where the requirements would impose an extreme hardship on the licensee. The request for a waiver must be in writing, state the circumstances that constitute extreme hardship, state the period of time the licensee wishes to have the continuing education requirement waived, and state the alternative measures that will be taken if a waiver is granted. The ~~commissioner~~ board shall set forth, in writing, the reasons for granting or denying the waiver. Waivers granted by the ~~commissioner~~ board shall specify, in writing, the time limitation and required alternative measures to be taken by the licensee. A request for waiver shall be denied if the ~~commissioner~~ board finds that the circumstances stated by the licensee do not support a claim of extreme hardship, the requested time period for waiver is unreasonable, the alternative measures proposed by the licensee are not equivalent to the continuing education activity being waived, or the request for waiver is not submitted to the ~~commissioner~~ board within 60 days after the expiration date.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 27. Minnesota Statutes 2016, section 148.6443, subdivision 8, is amended to read:

Subd. 8. **Penalties for noncompliance.** The ~~commissioner~~ board shall refuse to renew or grant, or shall suspend, condition, limit, or qualify the license of any person who the ~~commissioner~~ board determines has failed to comply with the continuing education requirements of this section. A licensee may request reconsideration of the ~~commissioner's~~ board's determination of noncompliance or the penalty imposed under this section by making a written request to the ~~commissioner~~ board within 30 days of the date of notification to the applicant. Individuals requesting reconsideration may submit information that the licensee wants considered in the reconsideration.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 28. Minnesota Statutes 2016, section 148.6445, subdivision 1, is amended to read:

Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists is $145. The initial licensure fee for occupational therapy assistants is $80. The ~~commissioner~~ board shall prorate fees based on the number of quarters remaining in the biennial licensure period.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 29. Minnesota Statutes 2016, section 148.6445, subdivision 10, is amended to read:

Subd. 10. **Use of fees.** All fees are nonrefundable. The ~~commissioner~~ 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. ~~Surcharges collected by the commissioner of health under section 16E.22 are not subject to this subdivision.~~

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 30. Minnesota Statutes 2016, section 148.6448, is amended to read:

148.6448 GROUNDS FOR DENIAL OF LICENSURE OR DISCIPLINE; INVESTIGATION PROCEDURES; DISCIPLINARY ACTIONS.

Subdivision 1. **Grounds for denial of licensure or discipline.** The ~~commissioner~~ board may deny an application for licensure, may approve licensure with conditions, or may discipline a licensee using any disciplinary actions listed in subdivision 3 on proof that the individual has:

(1) intentionally submitted false or misleading information to the ~~commissioner~~ board or the advisory council;

(2) failed, within 30 days, to provide information in response to a written request by the ~~commissioner~~ board or advisory council;

(3) performed services of an occupational therapist or occupational therapy assistant in an incompetent manner or in a manner that falls below the community standard of care;

(4) failed to satisfactorily perform occupational therapy services during a period of temporary licensure;

(5) violated sections 148.6401 to ~~148.6450~~ 148.6449;

(6) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(7) been convicted of violating any state or federal law, rule, or regulation which directly relates to the practice of occupational therapy;

(8) aided or abetted another person in violating any provision of sections 148.6401 to ~~148.6450~~ 148.6449;

(9) been disciplined for conduct in the practice of an occupation by the state of Minnesota, another jurisdiction, or a national professional association, if any of the grounds for discipline are the same or substantially equivalent to those in sections 148.6401 to ~~148.6450~~ 148.6449;

(10) not cooperated with the ~~commissioner or advisory council~~ board in an investigation conducted according to subdivision 2;

(11) advertised in a manner that is false or misleading;

(12) engaged in dishonest, unethical, or unprofessional conduct in connection with the practice of occupational therapy that is likely to deceive, defraud, or harm the public;

(13) demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(14) performed medical diagnosis or provided treatment, other than occupational therapy, without being licensed to do so under the laws of this state;

(15) paid or promised to pay a commission or part of a fee to any person who contacts the occupational therapist for consultation or sends patients to the occupational therapist for treatment;

(16) engaged in an incentive payment arrangement, other than that prohibited by clause (15), that promotes occupational therapy overutilization, whereby the referring person or person who controls the availability of occupational therapy services to a client profits unreasonably as a result of client treatment;

(17) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(18) obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

(19) performed services for a client who had no possibility of benefiting from the services;

(20) failed to refer a client for medical evaluation when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

(21) engaged in conduct with a client that is sexual or may reasonably be interpreted by the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(22) violated a federal or state court order, including a conciliation court judgment, or a disciplinary order issued by the ~~commissioner~~ board, related to the person's occupational therapy practice; or

(23) any other just cause related to the practice of occupational therapy.

Subd. 2. **Investigation of complaints.** The ~~commissioner, or the advisory council when authorized by the commissioner,~~ board may initiate an investigation upon receiving a complaint or other oral or written communication that alleges or implies that a person has violated sections 148.6401 to ~~148.6450~~ 148.6449. In the receipt, investigation, and hearing of a complaint that alleges or implies a person has violated sections 148.6401 to ~~148.6450~~ 148.6449, the ~~commissioner~~ board shall follow the procedures in section 214.10.

Subd. 3. **Disciplinary actions.** If the ~~commissioner~~ board finds that an occupational therapist or occupational therapy assistant should be disciplined according to subdivision 1, the ~~commissioner~~ board may take any one or more of the following actions:

(1) refuse to grant or renew licensure;

(2) approve licensure with conditions;

(3) revoke licensure;

(4) suspend licensure;

(5) any reasonable lesser action including, but not limited to, reprimand or restriction on licensure; or

(6) any action authorized by statute.

Subd. 4. **Effect of specific disciplinary action on use of title.** Upon notice from the ~~commissioner~~ board denying licensure renewal or upon notice that disciplinary actions have been imposed and the person is no longer entitled to practice occupational therapy and use the occupational therapy and licensed titles, the person shall cease to practice occupational therapy, to use titles protected by sections 148.6401 to ~~148.6450~~ 148.6449, and to represent to the public that the person is licensed by the ~~commissioner~~ board.

Subd. 5. **Reinstatement requirements after disciplinary action.** A person who has had licensure suspended may request and provide justification for reinstatement following the period of suspension specified by the ~~commissioner~~ board. The requirements of sections 148.6423 and 148.6425 for renewing licensure and any other conditions imposed with the suspension must be met before licensure may be reinstated.

Subd. 6. **Authority to contract.** The ~~commissioner~~ board shall contract with the health professionals services program as authorized by sections 214.31 to 214.37 to provide these services to practitioners under this chapter. The health professionals services program does not affect the ~~commissioner's~~ board's authority to discipline violations of sections 148.6401 to ~~148.6450~~ 148.6449.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 31. **[148.6449] BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

Subdivision 1. **Creation.** The Board of Occupational Therapy Practice consists of 11 members appointed by the governor. The members are:

(1) five occupational therapists licensed under sections 148.6401 to 148.6449;

(2) three occupational therapy assistants licensed under sections 148.6401 to 148.6449; and

(3) three public members, including two members who have received occupational therapy services or have a family member who has received occupational therapy services, and one member who is a health care professional or health care provider licensed in Minnesota.

Subd. 2. **Qualifications of board members.** (a) The occupational therapy practitioners appointed to the board must represent a variety of practice areas and settings.

(b) At least two occupational therapy practitioners must be employed outside the seven-county metropolitan area.

(c) Board members shall serve for not more than two consecutive terms.

Subd. 3. **Recommendations for appointment.** Prior to the end of the term of a member of the board, or within 60 days after a position on the board becomes vacant, the Minnesota Occupational Therapy Association and other interested persons and organizations may recommend to the governor members qualified to serve on the board. The governor may appoint members to the board from the list of persons recommended or from among other qualified candidates.

Subd. 4. **Officers.** The board shall biennially elect from its membership a chair, vice-chair, and secretary-treasurer. Each officer shall serve until a successor is elected.

Subd. 5. **Executive director.** The board shall appoint and employ an executive director who is not a member of the board. The employment of the executive director shall be subject to the terms described in section 214.04, subdivision 2a.

Subd. 6. **Terms; compensation; removal of members.** Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements shall be as provided in chapter 214. The provision of staff, administrative services, and office space; the review and processing of complaints; the setting of board fees; and other activities relating to board operations shall be conducted according to chapter 214.

Subd. 7. **Duties of the Board of Occupational Therapy Practice.** (a) The board shall:

(1) adopt and enforce rules and laws necessary for licensing occupational therapy practitioners;

(2) adopt and enforce rules for regulating the professional conduct of the practice of occupational therapy;

(3) issue licenses to qualified individuals in accordance with sections 148.6401 to 148.6449;

(4) assess and collect fees for the issuance and renewal of licenses;

(5) educate the public about the requirements for licensing occupational therapy practitioners, educate occupational therapy practitioners about the rules of conduct, and enable the public to file complaints against applicants and licensees who may have violated sections 148.6401 to 148.6449; and

(6) investigate individuals engaging in practices that violate sections 148.6401 to 148.6449 and take necessary disciplinary, corrective, or other action according to section 148.6448.

(b) The board may adopt rules necessary to define standards or carry out the provisions of sections 148.6401 to 148.6449. Rules shall be adopted according to chapter 14.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 32. Minnesota Statutes 2016, section 148.881, is amended to read:

148.881 DECLARATION OF POLICY.

The practice of psychology in Minnesota affects the public health, safety, and welfare. The regulations in ~~sections 148.88 to 148.98~~ the Minnesota Psychology Practice Act as enforced by the Board of Psychology protect the public ~~from the practice of psychology by unqualified persons and from unethical or unprofessional conduct by persons licensed to practice psychology~~ through licensure and regulation to promote access to safe, ethical, and competent psychological services.

Sec. 33. Minnesota Statutes 2016, section 148.89, is amended to read:

148.89 DEFINITIONS.

Subdivision 1. **Applicability.** For the purposes of sections 148.88 to 148.98, the following terms have the meanings given them.

Subd. 2. **Board of Psychology or board.** "Board of Psychology" or "board" means the board established under section 148.90.

Subd. 2a. **Client.** "Client" means ~~each individual or legal, religious, academic, organizational, business, governmental, or other entity that receives, received, or should have received, or arranged for another individual or entity to receive services from an individual regulated under sections 148.88 to 148.98. Client also means an individual's legally authorized representative, such as a parent or guardian. For the purposes of sections 148.88 to 148.98, "client" may include patient, resident, counselee, evaluatee, and, as limited in the rules of conduct, student, supervisee, or research subject. In the case of dual clients, the licensee or applicant for licensure must be aware of the responsibilities to each client, and of the potential for divergent interests of each client~~ a direct recipient of psychological services within the context of a professional relationship that may include a child, adolescent, adult, couple, family, group, organization, community, or other entity. The client may be the person requesting the psychological services or the direct recipient of the services.

Subd. 2b. **Credentialed.** "Credentialed" means having a license, certificate, charter, registration, or similar authority to practice in an occupation regulated by a governmental board or agency.

Subd. 2c. **Designated supervisor.** "Designated supervisor" means a qualified individual who is ~~designated~~ identified and assigned by the primary supervisor to provide additional supervision and training ~~to a licensed psychological practitioner or~~ to an individual who is obtaining required predegree supervised professional experience or postdegree supervised psychological employment.

Subd. 2d. **Direct services.** "Direct services" means the delivery of preventive, diagnostic, assessment, or therapeutic intervention services where the primary purpose is to benefit a client who is the direct recipient of the service.

Subd. 2e. **Full-time employment.** "Full-time employment" means a minimum of 35 clock hours per week.

Subd. 3. **Independent practice.** "Independent practice" means the practice of psychology without supervision.

Subd. 3a. **Jurisdiction.** "Jurisdiction" means the United States, United States territories, or Canadian provinces or territories.

Subd. 4. **Licensee.** "Licensee" means a person who is licensed by the board ~~as a licensed psychologist or as a licensed psychological practitioner~~.

Subd. 4a. **Provider or provider of services.** "Provider" or "provider of services" means any individual who is regulated by the board~~, and includes a licensed psychologist, a licensed psychological practitioner, a licensee, or an applicant~~.

Subd. 4b. **Primary supervisor.** "Primary supervisor" means a psychologist licensed in Minnesota or other qualified individual who provides the principal supervision ~~to a licensed psychological practitioner or~~ to an individual who is obtaining required predegree supervised professional experience or postdegree supervised psychological employment.

Subd. 5. **Practice of psychology.** "Practice of psychology" means the observation, description, evaluation, interpretation, ~~or~~ prediction, or modification of human behavior by the application of psychological principles, methods, or procedures for ~~any reason, including to prevent, eliminate, or manage~~ the purpose of preventing, eliminating, evaluating, assessing, or predicting symptomatic, maladaptive, or undesired behavior; applying psychological principles in legal settings; and ~~to enhance~~ enhancing interpersonal relationships, work, life and developmental adjustment, personal and organizational effectiveness, behavioral health, and mental health. The practice of psychology includes, but is not limited to, the following services, regardless of whether the provider receives payment for the services:

(1) psychological research and teaching of psychology subject to the exemptions in section 148.9075;

(2) ~~assessment, including psychological testing and other means of evaluating personal characteristics such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning~~ psychological testing and the evaluation or assessment of

personal characteristics, such as intelligence, personality, cognitive, physical and emotional abilities, skills, interests, aptitudes, and neuropsychological functioning;

(3) ~~a psychological report, whether written or oral, including testimony of a provider as an expert witness, concerning the characteristics of an individual or entity~~ counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy;

~~(4) psychotherapy, including but not limited to, categories such as behavioral, cognitive, emotive, systems, psychophysiological, or insight-oriented therapies; counseling; hypnosis; and diagnosis and treatment of:~~

~~(i) mental and emotional disorder or disability;~~

~~(ii) alcohol and substance dependence or abuse;~~

~~(iii) disorders of habit or conduct;~~

~~(iv) the psychological aspects of physical illness or condition, accident, injury, or disability, including the psychological impact of medications;~~

~~(v) life adjustment issues, including work-related and bereavement issues; and~~

~~(vi) child, family, or relationship issues~~

(4) diagnosis, treatment, and management of mental or emotional disorders or disabilities, substance use disorders, disorders of habit or conduct, and the psychological aspects of physical illness, accident, injury, or disability;

(5) ~~psychoeducational services and treatment~~ psychoeducational evaluation, therapy, and remediation; ~~and~~

(6) consultation ~~and supervision~~ with physicians, other health care professionals, and clients regarding available treatment options, including medication, with respect to the provision of care for a specific client;

(7) provision of direct services to individuals or groups for the purpose of enhancing individual and organizational effectiveness, using psychological principles, methods, and procedures to assess and evaluate individuals on personal characteristics for individual development or behavior change or for making decisions about the individual; and

(8) supervision and consultation related to any of the services described in this subdivision.

Subd. 6. **Telesupervision.** "Telesupervision" means the clinical supervision of psychological services through a synchronous audio and video format where the supervisor is not physically in the same facility as the supervisee.

Sec. 34. Minnesota Statutes 2016, section 148.90, subdivision 1, is amended to read:

Subdivision 1. **Board of Psychology.** (a) The Board of Psychology is created with the powers and duties described in this section. The board has 11 members who consist of:

(1) ~~three~~ four individuals licensed as licensed psychologists who have doctoral degrees in psychology;

(2) two individuals licensed as licensed psychologists who have master's degrees in psychology;

(3) two psychologists, not necessarily licensed, ~~one with a~~ who have doctoral ~~degree~~ degrees in psychology ~~and one with either a doctoral or master's degree in psychology~~ representing different training programs in psychology;

~~(4) one individual licensed or qualified to be licensed as: (i) through December 31, 2010, a licensed psychological practitioner; and (ii) after December 31, 2010, a licensed psychologist;~~ and

~~(5)~~ (4) three public members.

(b) After the date on which fewer than 30 percent of the individuals licensed by the board as licensed psychologists qualify for licensure under section 148.907, subdivision 3, paragraph (b), vacancies filled under paragraph (a), clause (2), shall be filled by an individual with either a master's or doctoral degree in psychology licensed or qualified to be licensed as a licensed psychologist.

(c) After the date on which fewer than 15 percent of the individuals licensed by the board as licensed psychologists qualify for licensure under section 148.907, subdivision 3, paragraph (b), vacancies under paragraph (a), clause (2), shall be filled by an individual with either a master's or doctoral degree in psychology licensed or qualified to be licensed as a licensed psychologist.

Sec. 35. Minnesota Statutes 2016, section 148.90, subdivision 2, is amended to read:

Subd. 2. **Members.** (a) The members of the board shall:

(1) be appointed by the governor;

(2) be residents of the state;

(3) serve for not more than two consecutive terms;

(4) designate the officers of the board; and

(5) administer oaths pertaining to the business of the board.

(b) A public member of the board shall represent the public interest and shall not:

(1) be a psychologist~~, psychological practitioner,~~ or have engaged in the practice of psychology;

(2) be an applicant or former applicant for licensure;

(3) be a member of another health profession and be licensed by a health-related licensing board as defined under section 214.01, subdivision 2; the commissioner of health; or licensed, certified, or registered by another jurisdiction;

(4) be a member of a household that includes a psychologist ~~or psychological practitioner~~; or

(5) have conflicts of interest or the appearance of conflicts with duties as a board member.

Sec. 36. Minnesota Statutes 2016, section 148.905, subdivision 1, is amended to read:

Subdivision 1. **General.** The board shall:

(1) adopt and enforce rules for licensing psychologists ~~and psychological practitioners~~ and for regulating their professional conduct;

(2) adopt and enforce rules of conduct governing the practice of psychology;

(3) adopt and implement rules for examinations which shall be held at least once a year to assess applicants' knowledge and skills. The examinations may be written or oral or both, and may be administered by the board or by institutions or individuals designated by the board~~;~~. Before the adoption and implementation of a new national examination, the board must consider whether the examination:

(i) demonstrates reasonable reliability and external validity;

(ii) is normed on a reasonable representative and diverse national sample; and

(iii) is intended to assess an applicant's education, training, and experience for the purpose of public protection;

(4) issue licenses to individuals qualified under sections 148.907 ~~and 148.908~~, 148.909, 148.915, and 148.916, according to the procedures for licensing in Minnesota Rules;

(5) issue copies of the rules for licensing to all applicants;

(6) establish and maintain annually a register of current licenses;

(7) establish and collect fees for the issuance and renewal of licenses and other services by the board. Fees shall be set to defray the cost of administering the provisions of sections 148.88 to 148.98 including costs for applications, examinations, enforcement, materials, and the operations of the board;

(8) educate the public ~~about~~ on the requirements for ~~licensing of psychologists and of psychological practitioners~~ licenses issued by the board and ~~about~~ on the rules of conduct~~, to~~;

(9) enable the public to file complaints against applicants or licensees who may have violated the Psychology Practice Act; ~~and~~

~~(9)~~ (10) adopt and implement requirements for continuing education; and

(11) establish or approve programs that qualify for professional psychology continuing educational credit. The board may hire consultants, agencies, or professional psychological associations to establish and approve continuing education courses.

Sec. 37. Minnesota Statutes 2016, section 148.907, subdivision 1, is amended to read:

Subdivision 1. **Effective date.** ~~After August 1, 1991,~~ No person shall engage in the independent practice of psychology unless that person is licensed as a licensed psychologist or is exempt under section 148.9075.

Sec. 38. Minnesota Statutes 2016, section 148.907, subdivision 2, is amended to read:

Subd. 2. **Requirements for licensure as licensed psychologist.** To become licensed by the board as a licensed psychologist, an applicant shall comply with the following requirements:

(1) pass an examination in psychology;

(2) pass a professional responsibility examination on the practice of psychology;

(3) pass any other examinations as required by board rules;

(4) pay nonrefundable fees to the board for applications, processing, testing, renewals, and materials;

(5) ~~have~~ attained the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction;

(6) ~~have~~ earned a doctoral degree with a major in psychology from a regionally accredited educational institution meeting the standards the board has established by rule; and

(7) ~~have~~ completed at least one full year or the equivalent in part time of postdoctoral supervised psychological employment in no less than 12 months and no more than 60 months. If the postdoctoral supervised psychological employment goes beyond 60 months, the board may grant a variance to this requirement.

Sec. 39. **[148.9075] EXEMPTIONS TO LICENSE REQUIREMENT.**

Subdivision 1. **General.** (a) Nothing in sections 148.88 to 148.98 shall prevent members of other professions or occupations from performing functions for which they are competent and properly authorized by law. The following individuals are exempt from the licensure requirements of the Minnesota Psychology Practice Act, provided they operate in compliance with the stated exemption:

(1) individuals licensed by a health-related licensing board as defined under section 214.01, subdivision 2, or by the commissioner of health;

(2) individuals authorized as mental health practitioners as defined under section 245.462, subdivision 17; and

(3) individuals authorized as mental health professionals under section 245.462, subdivision 18.

(b) Any of these individuals must not hold themselves out to the public by any title or description stating or implying they are licensed to engage in the practice of psychology unless they are licensed under sections 148.88 to 148.98 or are using a title in compliance with section 148.96.

Subd. 2. **Business or industrial organization.** Nothing in sections 148.88 to 148.98 shall prevent the use of psychological techniques by a business or industrial organization for its own personnel purposes or by an employment agency or state vocational rehabilitation agency for the evaluation of the agency's clients prior to a recommendation for employment. However, a representative of an industrial or business firm or corporation may not sell, offer, or provide psychological services as specified in section 148.89, unless the services are performed or supervised by an individual licensed under sections 148.88 to 148.98.

Subd. 3. **School psychologist.** (a) Nothing in sections 148.88 to 148.98 shall be construed to prevent a person who holds a license or certificate issued by the State Board of Teaching in accordance with chapters 122A and 129 from practicing school psychology within the scope of employment if authorized by a board of education or by a private school that meets

the standards prescribed by the State Board of Teaching, or from practicing as a school psychologist within the scope of employment in a program for children with disabilities.

(b) Any person exempted under this subdivision shall not offer psychological services to any other individual, organization, or group for remuneration, monetary or otherwise, unless the person is licensed by the Board of Psychology under sections 148.88 to 148.98.

Subd. 4. **Clergy or religious officials.** Nothing in sections 148.88 to 148.98 shall be construed to prevent recognized religious officials, including ministers, priests, rabbis, imams, Christian Science practitioners, and other persons recognized by the board, from conducting counseling activities that are within the scope of the performance of their regular recognizable religious denomination or sect, as defined in current federal tax regulations, if the religious official does not refer to the official's self as a psychologist and the official remains accountable to the established authority of the religious denomination or sect.

Subd. 5. **Teaching and research.** Nothing in sections 148.88 to 148.98 shall be construed to prevent a person employed in a secondary, postsecondary, or graduate institution from teaching and conducting research in psychology within an educational institution that is recognized by a regional accrediting organization or by a federal, state, county, or local government institution, agency, or research facility, so long as:

(1) the institution, agency, or facility provides appropriate oversight mechanisms to ensure public protections; and

(2) the person is not providing direct clinical services to a client or clients as defined in sections 148.88 to 148.98.

Subd. 6. **Psychologist in disaster or emergency relief.** Nothing in sections 148.88 to 148.98 shall be construed to prevent a psychologist sent to this state for the sole purpose of responding to a disaster or emergency relief effort of the state government, the federal government, the American Red Cross, or other disaster or emergency relief organization as long as the psychologist is not practicing in Minnesota longer than 30 days and the sponsoring organization can certify the psychologist's assignment to this state. The board or its designee, at its discretion, may grant an extension to the 30-day time limitation of this subdivision.

Subd. 7. **Psychological consultant.** A license under sections 148.88 to 148.98 is not required by a nonresident of the state, serving as an expert witness, organizational consultant, presenter, or educator on a limited basis provided the person is appropriately trained, educated, or has been issued a license, certificate, or registration by another jurisdiction.

Subd. 8. **Students.** Nothing in sections 148.88 to 148.98 shall prohibit the practice of psychology under qualified supervision by a practicum psychology student, a predoctoral psychology intern, or an individual who has earned a doctoral degree in psychology and is in the process of completing their postdoctoral supervised psychological employment. A student trainee or intern shall use the titles as required under section 148.96, subdivision 3.

Subd. 9. **Other professions.** Nothing in sections 148.88 to 148.98 shall be construed to authorize a person licensed under sections 148.88 to 148.98 to engage in the practice of any profession regulated under Minnesota law, unless the individual is duly licensed or registered in that profession.

Sec. 40. **[148.9077] RELICENSURE.**

A former licensee may apply to the board for licensure after complying with all laws and rules required for applicants for licensure that were in effect on the date the initial Minnesota license was granted. The former licensee must verify to the board that the former licensee has not engaged in the practice of psychology in this state since the last date of active licensure, except as permitted under statutory licensure exemption, and must submit a fee for relicensure.

Sec. 41. Minnesota Statutes 2016, section 148.9105, subdivision 1, is amended to read:

Subdivision 1. **Application.** Retired providers who are licensed or were formerly licensed to practice psychology in the state according to the Minnesota Psychology Practice Act may apply to the board for psychologist emeritus registration ~~or psychological practitioner emeritus registration~~ if they declare that they are retired from the practice of psychology in Minnesota, have not been the subject of disciplinary action in any jurisdiction, and have no unresolved complaints in any jurisdiction. Retired providers shall complete the necessary forms provided by the board and pay a onetime, nonrefundable fee of $150 at the time of application.

Sec. 42. Minnesota Statutes 2016, section 148.9105, subdivision 4, is amended to read:

Subd. 4. **Documentation of status.** A provider granted emeritus registration shall receive a document certifying that emeritus status has been granted by the board and that the registrant has completed the registrant's active career as a psychologist ~~or psychological practitioner~~ licensed in good standing with the board.

Sec. 43. Minnesota Statutes 2016, section 148.9105, subdivision 5, is amended to read:

Subd. 5. **Representation to public.** In addition to the descriptions allowed in section 148.96, subdivision 3, paragraph (e), former licensees who have been granted emeritus registration may represent themselves as "psychologist emeritus" ~~or "psychological practitioner emeritus,"~~ but shall not represent themselves or allow themselves to be represented to the public as "licensed" or otherwise as current licensees of the board.

Sec. 44. Minnesota Statutes 2016, section 148.916, subdivision 1, is amended to read:

Subdivision 1. **Generally.** ~~If~~ (a) A nonresident of the state of Minnesota~~,~~ who is not seeking licensure in this state~~,~~ and who has been issued a license, certificate, or registration by another jurisdiction to practice psychology ~~at the doctoral level, wishes~~ and who intends to practice in Minnesota for more than ~~seven calendar~~ 30 days~~, the person~~ shall apply to the board for guest licensure~~, provided that~~. The psychologist's practice in Minnesota is limited to no more than nine consecutive months per calendar year. Application under this section shall be made no less than 30 days prior to the expected date of practice in Minnesota and shall be subject to approval by the board or its designee. ~~The board shall charge a nonrefundable fee for guest licensure. The board shall adopt rules to implement this section.~~

(b) To be eligible for licensure under this section, the applicant must:

(1) have a license, certification, or registration to practice psychology from another jurisdiction;

(2) have a doctoral degree in psychology from a regionally accredited institution;

(3) be of good moral character;

(4) have no pending complaints or active disciplinary or corrective actions in any jurisdiction;

(5) pass a professional responsibility examination designated by the board; and

(6) pay a fee to the board.

Sec. 45. Minnesota Statutes 2016, section 148.916, subdivision 1a, is amended to read:

Subd. 1a. **Applicants for licensure.** (a) An applicant who is seeking licensure in this state, and who, at the time of application, is licensed, certified, or registered to practice psychology in another jurisdiction at the doctoral level may apply to the board for guest licensure in order to begin practicing psychology in this state while their application is being

processed if the applicant is of good moral character and has no complaints, corrective, or disciplinary action pending in any jurisdiction.

(b) Application under this ~~section~~ subdivision shall be made no less than 30 days prior to the expected date of practice in this state, and must be made concurrently or after submission of an application for licensure as a licensed psychologist if applicable. Applications under this ~~section~~ subdivision are subject to approval by the board or its designee. The board shall charge a fee for guest licensure under this subdivision.

~~(b) The board shall charge a nonrefundable fee for guest licensure under this subdivision.~~

(c) A guest license issued under this subdivision shall be valid for one year from the date of issuance, or until the board has either issued a license or has denied the applicant's application for licensure, whichever is earlier. Guest licenses issued under this ~~section~~ subdivision may be renewed annually until the board has denied the applicant's application for licensure.

Sec. 46. Minnesota Statutes 2016, section 148.925, is amended to read:

148.925 SUPERVISION.

Subdivision 1. **Supervision.** For the purpose of meeting the requirements of ~~this section~~ the Minnesota Psychology Practice Act, supervision means documented in-person consultation~~, which may include interactive, visual electronic communication, between either: (1) a primary supervisor and a licensed psychological practitioner; or (2) a~~ that employs a collaborative relationship that has both facilitative and evaluative components with the goal of enhancing the professional competence and science, and practice-informed professional work of the supervisee. Supervision may include telesupervision between primary or designated ~~supervisor~~ supervisors and ~~an applicant for licensure as a licensed psychologist~~ the supervisee. The supervision shall be adequate to assure the quality and competence of the activities supervised. Supervisory consultation shall include discussions on the nature and content of the practice of the supervisee, including, but not limited to, a review of a representative sample of psychological services in the supervisee's practice.

Subd. 2. **Postdegree supervised psychological employment.** Postdegree supervised psychological employment means required paid or volunteer work experience and postdegree training of an individual seeking to be licensed as a licensed psychologist that involves the professional oversight by a primary supervisor and satisfies the supervision requirements in ~~subdivisions 3 and 5~~ the Minnesota Psychology Practice Act.

Subd. 3. **Individuals qualified to provide supervision.** ~~(a) Supervision of a master's level applicant for licensure as a licensed psychologist shall be provided by an individual:~~

~~(1) who is a psychologist licensed in Minnesota with competence both in supervision in the practice of psychology and in the activities being supervised;~~

~~(2) who has a doctoral degree with a major in psychology, who is employed by a regionally accredited educational institution or employed by a federal, state, county, or local government institution, agency, or research facility, and who has competence both in supervision in the practice of psychology and in the activities being supervised, provided the supervision is being provided and the activities being supervised occur within that regionally accredited educational institution or federal, state, county, or local government institution, agency, or research facility;~~

~~(3) who is licensed or certified as a psychologist in another jurisdiction and who has competence both in supervision in the practice of psychology and in the activities being supervised; or~~

~~(4) who, in the case of a designated supervisor, is a master's or doctorally prepared mental health professional.~~

~~(b)~~ Supervision of ~~a doctoral level~~ an applicant for licensure as a licensed psychologist shall be provided by an individual:

(1) who is a psychologist licensed in Minnesota with a doctoral degree and competence both in supervision in the practice of psychology and in the activities being supervised;

(2) who has a doctoral degree with a major in psychology, who is employed by a regionally accredited educational institution or is employed by a federal, state, county, or local government institution, agency, or research facility, and who has competence both in supervision in the practice of psychology and in the activities being supervised, provided the supervision is being provided and the activities being supervised occur within that regionally accredited educational institution or federal, state, county, or local government institution, agency, or research facility;

(3) who is licensed or certified as a psychologist in another jurisdiction and who has competence both in supervision in the practice of psychology and in the activities being supervised;

(4) who is a psychologist licensed in Minnesota who was licensed before August 1, 1991, with competence both in supervision in the practice of psychology and in the activities being supervised; or

(5) who, in the case of a designated supervisor, is a master's or doctorally prepared mental health professional.

~~Subd. 4. **Supervisory consultation for a licensed psychological practitioner.** Supervisory consultation between a supervising licensed psychologist and a supervised licensed psychological practitioner shall be at least one hour in duration and shall occur on an individual, in-person basis. A minimum of one hour of supervision per month is required for the initial 20 or fewer hours of psychological services delivered per month. For each additional 20 hours of psychological services delivered per month, an additional hour of supervision per month is required. When more than 20 hours of psychological services are provided in a week, no more than one hour of supervision is required per week.~~

Subd. 5. **Supervisory consultation for an applicant for licensure as a licensed psychologist.** Supervision of an applicant for licensure as a licensed psychologist shall include at least two hours of regularly scheduled in-person consultations per week for full-time employment, one hour of which shall be with the supervisor on an individual basis. The remaining hour may be with a designated supervisor. The board may approve an exception to the weekly supervision requirement for a week when the supervisor was ill or otherwise unable to provide supervision. The board may prorate the two hours per week of supervision for individuals preparing for licensure on a part-time basis. Supervised psychological employment does not qualify for licensure when the supervisory consultation is not adequate as described in subdivision 1, or in the board rules.

Subd. 6. **Supervisee duties.** ~~Individuals~~ Applicants preparing for licensure as a licensed psychologist during their postdegree supervised psychological employment may perform as part of their training any ~~functions~~ of the services specified in section 148.89, subdivision 5, but only under qualified supervision.

~~Subd. 7. **Variance from supervision requirements.** (a) An applicant for licensure as a licensed psychologist who entered supervised employment before August 1, 1991, may request a variance from the board from the supervision requirements in this section in order to continue supervision under the board rules in effect before August 1, 1991.~~

~~(b) After a licensed psychological practitioner has completed two full years, or the equivalent, of supervised post-master's degree employment meeting the requirements of subdivision 5 as it relates to preparation for licensure as a licensed psychologist, the board shall grant a variance from the supervision requirements of subdivision 4 or 5 if the licensed psychological practitioner presents evidence of:~~

~~(1) endorsement for specific areas of competency by the licensed psychologist who provided the two years of supervision;~~

~~(2) employment by a hospital or by a community mental health center or nonprofit mental health clinic or social service agency providing services as a part of the mental health service plan required by the Comprehensive Mental Health Act;~~

~~(3) the employer's acceptance of clinical responsibility for the care provided by the licensed psychological practitioner; and~~

~~(4) a plan for supervision that includes at least one hour of regularly scheduled individual in-person consultations per week for full-time employment. The board may approve an exception to the weekly supervision requirement for a week when the supervisor was ill or otherwise unable to provide supervision.~~

~~(c) Following the granting of a variance under paragraph (b), and completion of two additional full years or the equivalent of supervision and post-master's degree employment meeting the requirements of paragraph (b), the board shall grant a variance to a licensed psychological practitioner who presents evidence of:~~

~~(1) endorsement for specific areas of competency by the licensed psychologist who provided the two years of supervision under paragraph (b);~~

~~(2) employment by a hospital or by a community mental health center or nonprofit mental health clinic or social service agency providing services as a part of the mental health service plan required by the Comprehensive Mental Health Act;~~

~~(3) the employer's acceptance of clinical responsibility for the care provided by the licensed psychological practitioner; and~~

~~(4) a plan for supervision which includes at least one hour of regularly scheduled individual in-person supervision per month.~~

~~(d) The variance allowed under this section must be deemed to have been granted to an individual who previously received a variance under paragraph (b) or (c) and is seeking a new variance because of a change of employment to a different employer or employment setting. The deemed variance continues until the board either grants or denies the variance. An individual who has been denied a variance under this section is entitled to seek reconsideration by the board.~~

Sec. 47. Minnesota Statutes 2016, section 148.96, subdivision 3, is amended to read:

Subd. 3. **Requirements for representations to public.** (a) Unless licensed under sections 148.88 to 148.98, except as provided in paragraphs (b) through (e), persons shall not represent themselves or permit themselves to be represented to the public by:

(1) using any title or description of services incorporating the words "psychology," "psychological," "psychological practitioner," or "psychologist"; or

(2) representing that the person has expert qualifications in an area of psychology.

(b) Psychologically trained individuals who are employed by an educational institution recognized by a regional accrediting organization, by a federal, state, county, or local government institution, agency, or research facility, may represent themselves by the title designated by that organization provided that the title does not indicate that the individual is credentialed by the board.

(c) A psychologically trained individual from an institution described in paragraph (b) may offer lecture services and is exempt from the provisions of this section.

(d) A person who is preparing for the practice of psychology under supervision in accordance with board statutes and rules may be designated as a "psychological intern," "psychology fellow," "psychological trainee," or by other terms clearly describing the person's training status.

(e) Former licensees who are completely retired from the practice of psychology may represent themselves using the descriptions in paragraph (a), clauses (1) and (2), but shall not represent themselves or allow themselves to be represented as current licensees of the board.

~~(f) Nothing in this section shall be construed to prohibit the practice of school psychology by a person licensed in accordance with chapters 122A and 129.~~

Sec. 48. Minnesota Statutes 2016, section 148B.53, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) To be licensed as a licensed professional counselor (LPC), an applicant must provide evidence satisfactory to the board that the applicant:

(1) is at least 18 years of age;

(2) is of good moral character;

(3) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board based on the criteria in paragraph (b), that includes a minimum of 48 semester hours or 72 quarter hours and a supervised field experience of not fewer than 700 hours that is counseling in nature;

(4) has submitted to the board a plan for supervision during the first 2,000 hours of professional practice or has submitted proof of supervised professional practice that is acceptable to the board; and

(5) has demonstrated competence in professional counseling by passing the National Counseling Exam (NCE) administered by the National Board for Certified Counselors, Inc. (NBCC) or an equivalent national examination as determined by the board, and ethical, oral, and situational examinations if prescribed by the board.

(b) The degree described in paragraph (a), clause (3), must be from a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or from an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA). Specific academic course content and training must include course work in each of the following subject areas:

(1) the helping relationship, including counseling theory and practice;

(2) human growth and development;

(3) lifestyle and career development;

(4) group dynamics, processes, counseling, and consulting;

(5) assessment and appraisal;

(6) social and cultural foundations, including multicultural issues;

(7) principles of etiology, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;

(8) family counseling and therapy;

(9) research and evaluation; and

(10) professional counseling orientation and ethics.

~~(c) To be licensed as a professional counselor, a psychological practitioner licensed under section 148.908 need only show evidence of licensure under that section and is not required to comply with paragraph (a), clauses (1) to (3) and (5), or paragraph (b).~~

~~(d)~~ (c) To be licensed as a professional counselor, a Minnesota licensed psychologist need only show evidence of licensure from the Minnesota Board of Psychology and is not required to comply with paragraph (a) or (b).

Sec. 49. Minnesota Statutes 2016, section 150A.06, subdivision 3, is amended to read:

Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists ~~or~~, 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~~, in dental school as to dentists, or dental hygiene school as to dental hygienists~~.

(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. 50. Minnesota Statutes 2016, section 150A.06, subdivision 8, is amended to read:

Subd. 8. **Licensure by credentials.** (a) Any dental assistant may, upon application and payment of a fee established by the board, apply for licensure based on an evaluation of the applicant's education, experience, and performance record in lieu of completing a board-approved dental assisting program for expanded functions as defined in rule, and may be interviewed by the board to determine if the applicant:

(1) has graduated from an accredited dental assisting program accredited by the Commission on Dental Accreditation~~, or~~ and is currently certified by the Dental Assisting National Board;

(2) is not subject to any pending or final disciplinary action in another state or Canadian province, or if not currently certified or registered, previously had a certification or

registration in another state or Canadian province in good standing that was not subject to any final or pending disciplinary action at the time of surrender;

(3) is of good moral character and abides by professional ethical conduct requirements;

(4) at board discretion, has passed a board-approved English proficiency test if English is not the applicant's primary language; and

(5) has met all expanded functions curriculum equivalency requirements of a Minnesota board-approved dental assisting program.

(b) The board, at its discretion, may waive specific licensure requirements in paragraph (a).

(c) An applicant who fulfills the conditions of this subdivision and demonstrates the minimum knowledge in dental subjects required for licensure under subdivision 2a must be licensed to practice the applicant's profession.

(d) If the applicant does not demonstrate the minimum knowledge in dental subjects required for licensure under subdivision 2a, the application must be denied. If licensure is denied, the board may notify the applicant of any specific remedy that the applicant could take which, when passed, would qualify the applicant for licensure. A denial does not prohibit the applicant from applying for licensure under subdivision 2a.

(e) A candidate whose application has been denied may appeal the decision to the board according to subdivision 4a.

Sec. 51. Minnesota Statutes 2016, section 150A.10, subdivision 4, is amended to read:

Subd. 4. **Restorative procedures.** (a) Notwithstanding subdivisions 1, 1a, and 2, a licensed dental hygienist or licensed dental assistant may perform the following restorative procedures:

(1) place, contour, and adjust amalgam restorations;

(2) place, contour, and adjust glass ionomer;

(3) adapt and cement stainless steel crowns; and

~~(4) place, contour, and adjust class I and class V supragingival composite restorations where the margins are entirely within the enamel; and~~

~~(5)~~ (4) place, contour, and adjust class I, II, and ~~class~~ V supragingival composite restorations on primary ~~teeth~~ and permanent dentition.

(b) The restorative procedures described in paragraph (a) may be performed only if:

(1) the licensed dental hygienist or licensed dental assistant has completed a board-approved course on the specific procedures;

(2) the board-approved course includes a component that sufficiently prepares the licensed dental hygienist or licensed dental assistant to adjust the occlusion on the newly placed restoration;

(3) a licensed dentist or licensed advanced dental therapist has authorized the procedure to be performed; and

(4) a licensed dentist or licensed advanced dental therapist is available in the clinic while the procedure is being performed.

(c) The dental faculty who teaches the educators of the board-approved courses specified in paragraph (b) must have prior experience teaching these procedures in an accredited dental education program.

Sec. 52. Minnesota Statutes 2016, section 214.01, subdivision 2, is amended to read:

Subd. 2. **Health-related licensing board.** "Health-related licensing board" means the Board of Examiners of Nursing Home Administrators established pursuant to section 144A.19, the Office of Unlicensed Complementary and Alternative Health Care Practice established pursuant to section 146A.02, the Board of Medical Practice created pursuant to section 147.01, the Board of Nursing created pursuant to section 148.181, the Board of Chiropractic Examiners established pursuant to section 148.02, the Board of Optometry established pursuant to section 148.52, the Board of Occupational Therapy Practice established pursuant to section 148.6449, the Board of Physical Therapy established pursuant to section 148.67, the Board of Psychology established pursuant to section 148.90, the Board of Social Work pursuant to section 148E.025, the Board of Marriage and Family Therapy pursuant to section 148B.30, the Board of Behavioral Health and Therapy established by section 148B.51, the Board of Dietetics and Nutrition Practice established under section 148.622, the Board of Dentistry established pursuant to section 150A.02, the Board of Pharmacy established pursuant to section 151.02, the Board of Podiatric Medicine established pursuant to section 153.02, and the Board of Veterinary Medicine established pursuant to section 156.01.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 53. **BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

The governor shall appoint all members to the Board of Occupational Therapy Practice under Minnesota Statutes, section 148.6449, by October 1, 2017. The governor shall designate one member of the board to convene the first meeting of the board by November 1, 2017. The board shall elect officers at its first meeting.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 54. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall replace references to Minnesota Statutes, section 148.6450, with Minnesota Statutes, section 148.6449.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 55. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the headnote of Minnesota Statutes, section 147.0375, to read "LICENSURE OF EMINENT PHYSICIANS."

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

Sec. 56. **REPEALER.**

(a) Minnesota Statutes 2016, sections 147A.21; 147B.08, subdivisions 1, 2, and 3; 147C.40, subdivisions 1, 2, 3, and 4; 148.906; 148.907, subdivision 5; 148.908; 148.909, subdivision 7; and 148.96, subdivisions 4 and 5, are repealed.

(b) Minnesota Statutes 2016, sections 148.6402, subdivision 2; and 148.6450, are repealed.

(c) Minnesota Rules, part 5600.2500, is repealed.

EFFECTIVE DATE. Paragraphs (a) and (c) are effective July 1, 2017. Paragraph (b) is effective January 1, 2018.

ARTICLE 12

OPIATE ABUSE PREVENTION

Section 1. Minnesota Statutes 2016, section 151.212, subdivision 2, is amended to read:

Subd. 2. **Controlled substances.** (a) In addition to the requirements of subdivision 1, when the use of any drug containing a controlled substance, as defined in chapter 152, or any other drug determined by the board, either alone or in conjunction with alcoholic

beverages, may impair the ability of the user to operate a motor vehicle, the board shall require by rule that notice be prominently set forth on the label or container. Rules promulgated by the board shall specify exemptions from this requirement when there is evidence that the user will not operate a motor vehicle while using the drug.

(b) In addition to the requirements of subdivision 1, whenever a prescription drug containing an opiate is dispensed to a patient for outpatient use, the pharmacy or practitioner dispensing the drug must prominently display on the label or container a notice that states "Caution: Opioid. Risk of overdose and addiction."

Sec. 2. Minnesota Statutes 2016, section 152.11, is amended by adding a subdivision to read:

Subd. 4. **Limit on quantity of opiates prescribed for acute dental and ophthalmic pain.** (a) When used for the treatment of acute dental pain or acute pain associated with refractive surgery, prescriptions for opiate or narcotic pain relievers listed in Schedules II through IV of section 152.02 shall not exceed a four-day supply. The quantity prescribed shall be consistent with the dosage listed in the professional labeling for the drug that has been approved by the United States Food and Drug Administration.

(b) For the purposes of this subdivision, "acute pain" means pain resulting from disease, accidental or intentional trauma, surgery, or another cause, that the practitioner reasonably expects to last only a short period of time. Acute pain does not include chronic pain or pain being treated as part of cancer care, palliative care, or hospice or other end-of-life care.

(c) Notwithstanding paragraph (a), if in the professional clinical judgment of a practitioner more than a four-day supply of a prescription listed in Schedules II through IV of section 152.02 is required to treat a patient's acute pain, the practitioner may issue a prescription for the quantity needed to treat such acute pain.

Sec. 3. **CHRONIC PAIN REHABILITATION THERAPY DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment.** The commissioner of human services shall award a two-year grant to a rehabilitation institute located in Minneapolis operated by a nonprofit foundation to participate in a bundled payment arrangement for chronic pain rehabilitation therapy for adults who are eligible for fee-for-service medical assistance under Minnesota Statutes, section 256B.055. The chronic pain rehabilitation therapy demonstration project must include: nonnarcotic medication management, including opioid tapering; interdisciplinary care coordination; and group and individual therapy in cognitive behavioral

therapy and physical therapy. The project may include self-management education in nutrition, stress, mental health, substance use, or other modalities, if clinically appropriate. The commissioner shall award the grant on a sole-source basis and the program design must be mutually agreed upon by the commissioner and the grant recipient. Grant funds are available until expended.

Subd. 2. **Performance measures.** The commissioner shall develop performance measures to evaluate the demonstration project. These measures may include:

(1) reduction in medications, including opioids, taken for pain;

(2) reduction in emergency department and outpatient clinic utilization related to pain;

(3) improved ability to return to work, job search, or school;

(4) patient functional status and satisfaction; and

(5) rate of program completion.

Subd. 3. **Eligibility.** (a) To be eligible to participate in the demonstration project, an individual must:

(1) be 21 years of age or older;

(2) be eligible for fee-for-service medical assistance under Minnesota Statutes, section 256B.055, and not have other health coverage; and

(3) meet criteria appropriate for chronic pain rehabilitation.

(b) In determining the criteria under paragraph (a), clause (3), the commissioner shall consider, but is not required to include, the following:

(1) moderate to severe pain lasting longer than four months;

(2) an impairment in daily functioning, including work or activities of daily living;

(3) a referral from a physician or other qualified medical professional indicating that all reasonable medical and surgical options have been exhausted; and

(4) willingness of the patient to engage in chronic pain rehabilitation therapies, including opioid tapering.

Subd. 4. **Payment for services.** The bundled payment shall be billed on a per-person, per-day payment and only for days the patient receives services from the grant recipient. The grant recipient shall not receive a bundled payment for services provided to the patient if a nonbundled medical assistance payment for a service that is part of the bundle is received for the same day of service.

Subd. 5. **Report.** The rehabilitation institute, for the duration of the demonstration project, must annually report on cost savings and performance indicators described in subdivision 2 to the commissioner of human services. One year after the completion of the demonstration project, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report shall include an evaluation of the demonstration project, based on the performance measures developed under subdivision 2, and may also include recommendations to increase individual access to chronic pain rehabilitation therapy through Minnesota health care programs.

Sec. 4. **SUBSTANCE USE DISORDER PROVIDER CAPACITY GRANT PROGRAM.**

The commissioner of human services shall design and implement a grant program to assist providers to purchase the first dose of a nonnarcotic injectable or implantable medication to treat substance use disorder for medical assistance enrollees. Grants shall be distributed between July 1, 2017, and June 30, 2019. The commissioner shall conduct outreach to providers regarding the availability of this grant and ensure a simplified grant application process. The commissioner shall provide technical assistance to assist providers in building operational capacity to treat substance use disorders with nonnarcotic injectable or implantable medications. The commissioner, in collaboration with stakeholders, shall analyze the impact of the grant program under this section and the actual or perceived barriers for providers to access and be reimbursed for nonnarcotic injectable or implantable substance use disorder medications and develop recommendations for addressing identified barriers. The commissioner shall provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by September 1, 2019.

ARTICLE 13

MISCELLANEOUS

Section 1. Minnesota Statutes 2016, section 62K.15, is amended to read:

62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT PERIODS.

(a) Health carriers offering individual health plans must limit annual enrollment in the individual market to the annual open enrollment periods for MNsure. Nothing in this section

limits the application of special or limited open enrollment periods as defined under the Affordable Care Act.

(b) Health carriers offering individual health plans must inform all applicants at the time of application and enrollees at least annually of the open and special enrollment periods as defined under the Affordable Care Act.

(c) Health carriers offering individual health plans must provide a special enrollment period for enrollment in the individual market by employees of a small employer that offers a qualified small employer health reimbursement arrangement in accordance with United States Code, title 26, section 9831(d). The special enrollment period shall be available only to employees newly hired by a small employer offering a qualified small employer health reimbursement arrangement, and to employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement. For employees newly hired by the small employer, the special enrollment period shall last for 30 days after the employee's first day of employment. For employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement, the special enrollment period shall last for 30 days after the date the arrangement is initially offered to employees.

~~(c)~~ (d) The commissioner of commerce shall enforce this section.

Sec. 2. Minnesota Statutes 2016, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means ~~a public body, governmental agency, business entity, officer, owner, or managerial official whose responsibilities include the direction of the management or policies of a program. For purposes of this subdivision, owner means an individual who has direct or indirect ownership interest in a corporation, partnership, or other business association issued a license under this chapter. For purposes of this subdivision, managerial official means those individuals who have 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. Controlling individual does not include~~ 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); 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); ~~or~~

(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.

Sec. 3. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to read:

Subd. 10b. **Owner.** "Owner" means an individual or organization that has a direct or indirect ownership interest of five percent or more in a program licensed under this chapter. For purposes of this subdivision, "direct ownership interest" means the possession of equity in capital, stock, or profits of an organization, and "indirect ownership interest" means a direct ownership interest in an entity that has a direct or indirect ownership interest in a licensed program. For purposes of this chapter, "owner of a nonprofit corporation" means the president and treasurer of the board of directors or, for an entity owned by an employee stock ownership plan, means the president and treasurer of the entity. A government entity that is issued a license under this chapter shall be designated the owner.

ARTICLE 14

NURSING FACILITY TECHNICAL CORRECTIONS

Section 1. Minnesota Statutes 2016, section 144.0722, subdivision 1, as amended by Laws 2017, chapter 40, article 1, section 18, is amended to read:

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under section 144.0721, or under rules established by the commissioner of human services under ~~sections 256B.421 to 256B.48~~ chapter 256R. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Sec. 2. Minnesota Statutes 2016, section 144A.071, subdivision 3, as amended by Laws 2017, chapter 40, article 1, section 22, 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 section 144A.071, 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 payment rates shall be determined according to Minnesota Rules, part 9549.0057, using the limits under ~~chapter 256R~~ sections 256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates must be determined according to ~~chapter 256R~~ section 256R.25. 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.

(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.

Sec. 3. Minnesota Statutes 2016, section 144A.071, subdivision 4a, as amended by Laws 2017, chapter 40, article 1, section 23, 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, and the reimbursement provisions of ~~section 256B.431~~ chapter 256R. Property-related reimbursement rates shall be determined under section ~~256B.431~~ 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 ~~section 256B.431 or 256B.434, chapter 256R, or~~ Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section ~~256B.431 or 256B.434 or chapter 256R~~ 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 ~~chapter 256R~~ 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, and the reimbursement provisions of ~~section 256B.431~~ chapter 256R. Property-related reimbursement rates shall be determined under section ~~256B.431~~ 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 ~~section 256B.431~~ chapter 256R and Minnesota Rules, parts 9549.0010 to 9549.0080~~, or section 256B.434 or chapter 256R~~; 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.

Sec. 4. Minnesota Statutes 2016, section 144A.071, subdivision 4c, as amended by Laws 2017, chapter 40, article 1, section 24, 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, and the reimbursement provisions of ~~section 256B.431~~ 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.

Sec. 5. Minnesota Statutes 2016, section 144A.10, subdivision 4, as amended by Laws 2017, chapter 40, article 1, section 27, is amended to read:

Subd. 4. **Correction orders.** Whenever a duly authorized representative of the commissioner of health finds upon inspection of a nursing home, that the facility or a controlling person or an employee of the facility is not in compliance with sections 144.411 to 144.417, 144.651, 144.6503, 144A.01 to 144A.155, or 626.557 or the rules promulgated thereunder, a correction order shall be issued to the facility. The correction order shall state the deficiency, cite the specific rule or statute violated, state the suggested method of correction, and specify the time allowed for correction. If the commissioner finds that the nursing home had uncorrected or repeated violations which create a risk to resident care, safety, or rights, the commissioner shall notify the commissioner of human services ~~who~~

~~shall require the facility to use any incentive payments received under section 256R.38, to correct the violations and shall require the facility to forfeit incentive payments for failure to correct the violations. The forfeiture shall not apply to correction orders issued for physical plant deficiencies~~.

Sec. 6. Minnesota Statutes 2016, section 144A.74, is amended to read:

144A.74 MAXIMUM CHARGES.

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted average wage rate, plus a factor determined by the commissioner to incorporate payroll taxes as defined in ~~Minnesota Rules, part 9549.0020, subpart 33~~ section 256R.02, subdivision 37, for the applicable employee classification for the geographic group to which the nursing home is assigned under Minnesota Rules, part 9549.0052. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Wages are defined as hourly rate of pay and shift differential, including weekend shift differential and overtime. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home.

Sec. 7. Minnesota Statutes 2016, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must

acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to $2,815.

(e) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph (d) based on the commissioner's determination of a permissible surcharge.

~~(f) Between April 1, 2002, and August 15, 2004, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.~~

Sec. 8. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a). Effective on July 1 of the state fiscal year in which the resident assessment system as described in section ~~256B.438~~ 256R.17 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(h) Effective July 1, 2016, and each July 1 thereafter, individualized service rate limits for customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases

effective on July 1 or since the previous July 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ 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 July 1, or occurring since the previous July 1.

Sec. 9. Minnesota Statutes 2016, section 256B.35, subdivision 4, as amended by Laws 2017, chapter 40, article 1, section 72, is amended to read:

Subd. 4. **Field audits required.** The commissioner of human services shall conduct field audits at the same time as cost report audits required under section 256R.13, subdivision 1, and at any other time but at least once every four years, without notice, to determine whether this section was complied with and that the funds provided residents for their personal needs were actually expended for that purpose.

Sec. 10. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter which has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 or chapter 256R completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter, which has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section ~~or~~, section 256B.434, or chapter 256R, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section ~~or~~, section 256B.434, or chapter 256R, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

Sec. 11. **EFFECTIVE DATE.**

Sections 1 to 10 are effective the day following final enactment.

ARTICLE 15

MANAGED CARE ORGANIZATIONS

Section 1. Minnesota Statutes 2016, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. **Prepaid health plan appeals.** (a) All prepaid health plans under contract to the commissioner under chapter 256B must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is ~~not~~ required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services judge shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services judge may order a second medical opinion from ~~the prepaid health plan or may order a second medical opinion from~~ a nonprepaid health plan provider at the expense of the ~~prepaid health plan~~ Department of Human Services. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services judge shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

(d) Beginning January 1, 2018, the requirements of Code of Federal Regulations, part 42, sections 438.400 to 438.424, take precedent over any conflicting provisions in this subdivision. All other provisions of this section remain in effect.

Sec. 2. Minnesota Statutes 2016, section 256B.69, is amended by adding a subdivision to read:

Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee support system that provides support to an enrollee before and during enrollment in a managed care plan.

(b) The enrollee support system must:

(1) provide access to counseling for each potential enrollee on choosing a managed care plan;

(2) assist an enrollee in understanding enrollment in a managed care plan;

(3) provide an access point for complaints regarding enrollment, covered services, and other related matters;

(4) provide information on an enrollee's grievance and appeal rights within the managed care organization and the state's fair hearing process, including an enrollee's rights and responsibilities; and

(5) provide assistance to an enrollee, upon request, in navigating the grievance and appeals process within the managed care organization and in appealing adverse benefit determinations made by the managed care organization to the state's fair hearing process after the managed care organization's internal appeals process has been exhausted. Assistance does not include providing representation to an enrollee at the state's fair hearing, but may include a referral to appropriate legal representation sources.

(c) Outreach to enrollees through the support system must be accessible to an enrollee through multiple formats, including telephone, Internet, in-person, and, if requested, through auxiliary aids and services.

(d) The commissioner may designate enrollment brokers to assist enrollees on selecting a managed care organization and providing necessary enrollment information. For purposes of this subdivision, "enrollment broker" means an individual or entity that performs choice counseling or enrollment activities in accordance with Code of Federal Regulations, part 42, section 438.810, or both.

Sec. 3. Minnesota Statutes 2016, section 256B.69, is amended by adding a subdivision to read:

Subd. 37. **Networks.** (a) The commissioner shall ensure that a managed care organization's network providers are enrolled with the commissioner as medical assistance providers, and that the providers comply with the provider disclosure, screening, and enrollment requirements in Code of Federal Regulations, part 42, section 455. A provider that has a network provider contract with the managed care organization is not required to provide services to a medical assistance or MinnesotaCare recipient who is receiving services through the fee-for-service system.

(b) A managed care organization may enter into a network provider contract with a provider that is not a medical assistance provider for a period of up to 120 days pending the outcome of the medical assistance provider enrollment process. A managed care organization must terminate the contract upon notification that the provider cannot be enrolled as a medical assistance provider or upon expiration of the 120-day period if notification has not

been received within that period. The managed care organization must notify each affected enrollee of the provider contract termination.

(c) For purposes of this subdivision, "network provider" means any provider, group of providers, entity with a network provider agreement with the managed care organization, or subcontractor that receives payments from the managed care organization either directly or indirectly to provide services under a managed care contract between the commissioner and the managed care organization.

Sec. 4. **[256B.6925] ENROLLEE INFORMATION.**

Subdivision 1. **Information provided by the commissioner.** The commissioner shall provide to each potential enrollee the following information:

(1) basic features of receiving services through managed care;

(2) which individuals are excluded from managed care enrollment, subject to mandatory managed care enrollment, or who may choose to enroll voluntarily;

(3) for mandatory and voluntary enrollment, the length of the enrollment period and information about an enrollee's right to disenroll in accordance with Code of Federal Regulations, part 42, section 438.56;

(4) the service area covered by each managed care organization;

(5) covered services, including services provided by the managed care organization and services provided by the commissioner;

(6) the provider directory and drug formulary for each managed care organization;

(7) cost-sharing requirements;

(8) requirements for adequate access to services, including provider network adequacy standards;

(9) a managed care organization's responsibility for coordination of enrollee care; and

(10) quality and performance indicators, including enrollee satisfaction for each managed care organization, if available.

Subd. 2. **Information provided by the managed care organization.** The commissioner shall ensure that managed care organizations provide to each enrollee the following information:

(1) an enrollee handbook within a reasonable time after receiving notice of the enrollee's enrollment. The handbook must, at a minimum, include information on benefits provided,

how and where to access benefits, cost-sharing requirements, how transportation is provided, and other information as required by Code of Federal Regulations, part 42, section 438.10, paragraph (g);

(2) a provider directory for the following provider types: physicians, specialists, hospitals, pharmacies, behavioral health providers, and long-term supports and services providers, as appropriate. The directory must include the provider's name, group affiliation, street address, telephone number, Web site, specialty if applicable, whether the provider accepts new enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal Regulations, part 42, section 438.10, paragraph (h), and whether the provider's office accommodates people with disabilities;

(3) a drug formulary that includes both generic and name brand medications that are covered and each medication tier, if applicable;

(4) written notice of termination of a contracted provider. Within 15 calendar days after receipt or issuance of the termination notice, the managed care organization must make a good faith effort to provide notice to each enrollee who received primary care from, or was seen on a regular basis by, the terminated provider; and

(5) upon enrollee request, the managed care organization's physician incentive plan.

Subd. 3. **Provision of information.** (a) All information required to be provided to enrollees and potential enrollees of a managed care organization, including the provider directory, enrollee handbook, and drug formulary, must be provided in a manner and format that is easily understood and readily accessible. The information must be available through the enrollee support system established under section 256B.69, subdivision 36, the department's Web site and each managed care organization's Web site. The commissioner and managed care organization shall inform each enrollee that the information is available on the department's and the managed care organization's Web sites and shall provide the potential enrollee or enrollee with the applicable URL to access the information. An enrollee with a disability who cannot access the information online must be provided, upon request, with auxiliary aids and services necessary to access the information at no cost to the enrollee.

(b) The commissioner and managed care organization shall provide all required information electronically to potential enrollees and enrollees unless the enrollee requests the information in paper form. The commissioner and managed care organization shall inform an enrollee that, upon request, the information is available in paper form without charge to the enrollee, and shall mail the information to the potential enrollee's or the enrollee's mailing address within five business days of the request. If the information is

provided to the enrollee through e-mail, the managed care organization must receive the enrollee's agreement before providing the information by e-mail.

(c) The information required to be provided electronically to a potential enrollee or enrollee must:

(1) be readily accessible;

(2) be published in a prominent location on the commissioner's and managed care organization's Web sites in a format that has the capability of being retained and printed; and

(3) satisfy the requirements for content and language requirements in accordance with Code of Federal Regulations, part 42, section 438.10, paragraph (d).

Subd. 4. **Language and accessibility standards.** (a) Managed care contracts entered into under section 256B.69, 256B.692, or 256L.12, must require a managed care organization to provide language assistance, and auxiliary aids and services, if requested, to ensure access to a managed care organization's programs and services, as required under United States Code, title 42, sections 18116 and 2000d, and any other federal regulations or guidance from the United States Department of Health and Human Services.

(b) The commissioner shall establish a methodology to identify the prevalent non-English languages spoken by enrollees and potential enrollees throughout Minnesota and in each managed care organization's service area.

(c) The commissioner shall ensure that oral interpretation is provided in all languages and written interpretation is provided in each prevalent non-English language, and that both are available to enrollees and potential enrollees free of charge. Oral interpretation services shall include the use of auxiliary aids, TTY/TDY, and American sign language.

(d) All written materials that target potential enrollees and are provided to enrollees, including the provider directory, enrollee handbook, appeals and grievance notices, and denial and termination notices, must:

(1) use at least 12-point font;

(2) be written at a 7th grade reading level;

(3) be available in alternative formats and through auxiliary aids and services that consider the special needs of the enrollee, including an enrollee with a disability or limited English proficiency;

(4) use taglines that consist of short statements in each of the prevalent non-English languages, in an 18-point font, that explain the availability of language interpreter services free of charge; and

(5) explain how to request auxiliary aids and services, including the provision of the materials in alternative formats and the TTY/TDY telephone number of the managed care organization's customer service unit and the department's enrollee support system.

(e) For purposes of this subdivision, "prevalent non-English language" means a non-English language that is determined by the commissioner to be spoken by a significant number or percentage of potential enrollees and enrollees with limited proficiency in English.

Subd. 5. **Enrollee communication.** (a) The commissioner shall ensure that the managed care organization:

(1) submits all marketing materials to the commissioner for approval before distribution and that marketing materials are accurate and do not mislead, confuse, or defraud;

(2) distributes marketing materials to a managed care organization's entire service area and as otherwise permitted by contract;

(3) complies with the information requirements in Code of Federal Regulations, part 42, section 438.10;

(4) does not seek to influence enrollment with the sale or offering of any private insurance, with the exception of communications between an enrollee and a managed care organization that is related to the offering of a qualified health plan as defined under section 62K.03; and

(5) does not directly, or indirectly, engage in door-to-door, telephone, e-mail, texting, or other cold-call marketing activities.

(b) For the purposes of this subdivision, "cold-call marketing activities" means any unsolicited personal contact or communication by a managed care organization with an individual who is not enrolled in that managed care organization that can be reasonably interpreted as intended to influence the individual to enroll in a specific managed care organization or to not enroll in or disenroll from another managed care organization.

Sec. 5. **[256B.6926] STATE MONITORING.**

Subdivision 1. **Generally.** (a) The commissioner shall establish a monitoring system that addresses all aspects of the managed care program, including the performance of each

managed care organization in the areas identified under Code of Federal Regulations, part 42, section 438.66, paragraph (b).

(b) The commissioner shall use data collected from the monitoring activities, including, at a minimum, the data identified in Code of Federal Regulations, part 42, section 438.66, paragraph (c), to improve the performance of the managed care program.

Subd. 2. **Readiness review.** The commissioner shall conduct a readiness review of each managed care organization that contracts with the commissioner to assess the managed care organization's ability and capacity to perform satisfactorily in the areas described in Code of Federal Regulations, part 42, section 438.66, paragraph (d), clauses (1) to (4). The review must be conducted and approval must be received from the Centers for Medicare and Medicaid Services prior to the commissioner entering into a contract with the managed care organization.

Subd. 3. **Report.** (a) The commissioner shall submit to the Centers for Medicare and Medicaid Services, no later than 180 days after each contract year, a report on the managed care program administered by the commissioner, regardless of the authority under which the program operates, with the initial report being submitted 180 days after the contract year following the release of the Centers for Medicare and Medicaid Services guidance. Each report must, at a minimum, assess the managed care program's operation in the areas identified in Code of Federal Regulations, part 42, section 438.66, paragraph (e), clause (2), and must be:

(1) provided to the Medicaid Citizens' Advisory Committee as required under Code of Federal Regulations, part 42, section 431.12;

(2) provided to the stakeholder consultation group as required under Code of Federal Regulations, part 42, section 438.70, to the extent the managed care program includes long-term services and supports; and

(3) published on the department's Web site.

(b) The report described under this subdivision may be used to meet the commissioner's reporting obligation under the managed care waiver authority for the managed care program.

Subd. 4. **Conflicts of interest.** The commissioner shall implement safeguards against conflicts of interest on behalf of state and local officers and employees and agents of the state who have responsibilities relating to managed care contracts. The safeguards must be at least as effective as the safeguards specified in United States Code, title 41, sections 2101 to 2107. The commissioner shall comply with Code of Federal Regulations, part 42, section

438.58, and United States Code, title 42, section 1396a, paragraph (a), clause (4), item (c), applicable to contracting officers, employees, or independent contractors.

Sec. 6. **[256B.6927] QUALITY ASSESSMENT AND PERFORMANCE.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them.

(b) "Access" means the availability and timely use of services to achieve optimal outcomes as required under Code of Federal Regulations, part 42, sections 438.68 and 438.206.

(c) "External quality review" means the analysis and evaluation by an external quality review organization of the aggregated information on quality, timeliness, and access to the health care services that a managed care organization or the managed care organization's contractor provides to enrollees.

(d) "External quality review organization" means an organization that meets the competence and independence requirements under Code of Federal Regulations, part 42, section 438.354, and performs external quality review and may perform other external quality review-related activities as required under Code of Federal Regulations, part 42, section 438.358.

(e) "Quality" means the degree that a managed care organization increases the likelihood of desired outcomes of a managed care organization's enrollees through:

(1) a managed care organization's structural and operational characteristics;

(2) the provision of services that are consistent with current professional, evidence-based knowledge; and

(3) interventions for performance improvement.

(f) "Validation" means the review of information, data, and procedures to determine the extent that information, data, and procedures are accurate, reliable, free from bias, and according to standards for data collection and analysis.

Subd. 2. **Quality strategy.** (a) The commissioner shall implement a written quality strategy for assessing and improving the quality of health care and other services provided by managed care organizations. At a minimum, the quality strategy must include:

(1) defined network adequacy requirements and availability of services standards for managed care organizations, including examples of evidence-based clinical practice guidelines;

(2) measurable goals and objectives for continuous quality improvement that consider the health status of all populations served by the managed care organization;

(3) a description of:

(i) the quality metrics and performance targets used in measuring the performance and improvement of each managed care organization; and

(ii) performance improvement projects, including a description of any intervention proposed by the commissioner to improve access, quality, or timeliness of care for enrollees;

(4) annual, external independent reviews of quality outcomes, and the timeliness of and access to services covered by the managed care organization;

(5) a description of the managed care organization's transition of care policy;

(6) a plan to identify, evaluate, and reduce health disparities based on an enrollee's age, race, ethnicity, sex, primary language, or disability status, and provide this demographic information to the managed care organization at the time of enrollment;

(7) appropriate use of intermediate sanctions to be imposed on a managed care organization;

(8) the mechanisms implemented to identify enrollees who need long-term services and supports or enrollees with special health care needs; and

(9) information related to nonduplication of the external quality review activities in accordance with Code of Federal Regulations, part 42, section 438.360, paragraph (c).

(b) In developing the initial quality strategy, the commissioner shall:

(1) obtain input from the Medicaid Citizens' Advisory Committee, enrollees, and other interested stakeholders;

(2) consult with the tribes according to the tribal consultation policy;

(3) consider recommendations from the external quality review organization identified under subdivision 3, for improving the quality of health care services furnished by the managed care organization; and

(4) make the strategy available for public comment.

(c) The commissioner shall submit a copy of the initial quality strategy to the Centers for Medicare and Medicaid Services for comments and feedback. If significant changes are made based on the comments and feedback received, the commissioner shall publish the

revised quality strategy on the department's Web site. The commissioner shall make the final quality strategy available on the department's Web site.

(d) The commissioner shall review and update the quality strategy at least every three years or more frequently, if needed. The review shall include an evaluation of the effectiveness of the quality strategy conducted within the previous three years. The results of the review and any updates shall be published on the department's Web site.

Subd. 3. **External quality reviews.** (a) The commissioner shall contract with an external quality review organization in accordance with Code of Federal Regulations, part 42, section 438.354, to conduct an annual external quality review of each managed care organization. The commissioner shall ensure that all necessary information is provided to the external quality review organization for analysis and inclusion in the external quality review technical report required under paragraph (g). The information provided must be obtained in accordance with Code of Federal Regulations, part 42, section 438.352.

(b) The commissioner shall follow an open, competitive procurement process according to state and federal law for any contract with an external quality review organization. The external quality review organization may use a subcontractor if the subcontractor meets the requirements for independence. The external quality review organization is accountable for and must oversee all functions performed by the subcontractor.

(c) The following mandatory external quality review related activities must be performed for each managed care organization:

(1) validation of performance improvement projects, performance measures, and meeting network adequacy requirements for the 12 months preceding the most recently completed contract period; and

(2) review of the managed care organization's compliance with Code of Federal Regulations, part 42, subpart D, and section 438.330 for the preceding three years.

(d) The commissioner may elect to incorporate any of the optional activities listed in Code of Federal Regulations, part 42, section 438.358, paragraph (c), as part of the external quality review.

(e) To avoid duplication, the commissioner may use information from a Medicare or private accreditation review to provide information for a managed care organization's annual external quality review instead of conducting one or more of the mandatory external quality review activities. The information used must satisfy Code of Federal Regulations, part 42, section 438.360, paragraph (a).

(f) If the conditions in Code of Federal Regulations, part 42, section 438.362, are satisfied, the commissioner may accept the data, correspondence, information, and findings regarding the managed care organization's compliance with a Medicare quality review in lieu of performing an external quality review. For each managed care organization exempt from an external quality review, the commissioner shall obtain the most recent Medicare review findings or Medicare information from a private national accrediting organization that the Centers for Medicare and Medicaid Services approves and recognizes for Medicare Advantage Organization deeming.

(g) The qualified external quality review organization must produce an annual external quality review technical report in accordance with Code of Federal Regulations, part 42, section 438.364. The technical report must summarize findings on access and quality of care. The commissioner may revise the final external quality review technical report if there is evidence of error or omission. The final external quality review technical report must be published on the department's Web site by April 30 of each year and copies of the report must be made available upon request and in alternative formats. Information in the technical report must not disclose the identity or other protected patient identifying health information.

Sec. 7. **[256B.6928] MANAGED CARE RATES AND PAYMENTS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them.

(b) "Base amount" has the meaning given in Code of Federal Regulations, part 42, section 438.6, paragraph (a).

(c) "Budget neutral" has the meaning given in Code of Federal Regulations, part 42, section 438.5, paragraph (a).

(d) "Credibility adjustment" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(e) "Full credibility" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(f) "Incentive arrangement" has the meaning given in Code of Federal Regulations, part 42, section 438.6.

(g) "Medical loss ratio" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(h) "Medical loss ratio reporting year" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(i) "Member months" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(j) "No credibility" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(k) "Partial credibility" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(l) "Pass-through payment" has the meaning given in Code of Federal Regulations, part 42, section 438.6, paragraph (a).

(m) "Rate cell" has the meaning given in Code of Federal Regulations, part 42, section 438.2.

(n) "Risk adjustment" has the meaning given in Code of Federal Regulations, part 42, section 438.5, paragraph (a).

Subd. 2. **Actuarial soundness.** (a) Capitation rates for managed care organizations must be reviewed and approved by the Centers for Medicare and Medicaid Services as actuarially sound. The capitation rates must be provided in the format and time frame required by Code of Federal Regulations, part 42, section 438.7. Capitation rates must:

(1) be developed in accordance with the rates standards in Code of Federal Regulations, part 42, section 438.5, and generally accepted actuarial principles and practices. Any proposed differences in capitation rates between covered populations must be based on valid rate development standards and not on the rate of federal financial participation associated with the covered populations;

(2) be appropriate for the populations covered and the services furnished under the contract;

(3) meet the requirements for availability of services, adequate capacity, and coordination and continuity of care in accordance with Code of Federal Regulations, part 42, sections 438.206, 438.207, and 438.208;

(4) be specific to each rate cell under the contract, and must not cross-subsidize or be cross-subsidized by payments from any other rate cell;

(5) meet any special contract provisions in accordance with Code of Federal Regulations, part 42, section 438.6; and

(6) be developed to reasonably achieve a medical loss ratio standard of at least 85 percent for the rate year, or a higher minimum medical loss ratio if mandated by the commissioner, as long as the capitation rates are adequate for reasonable, appropriate, and attainable nonbenefit costs.

(b) An independent actuary must certify that the rates were developed in accordance with Code of Federal Regulations, part 42, section 438.3, paragraph (c), clause (1), item (ii), paragraph (e).

Subd. 3. **Rate development standards.** (a) In developing capitation rates, the commissioner shall:

(1) identify and develop base utilization and price data, including validated encounter data and audited financial reports received from the managed care organizations that demonstrate experience for the populations served by the managed care organizations, for the three most recent and complete years before the rating period;

(2) develop and apply reasonable trend factors, including cost and utilization, to base data that are developed from actual experience of the medical assistance population or a similar population according to generally accepted actuarial practices and principles;

(3) develop the nonbenefit component of the rate to account for reasonable expenses related to the managed care organization's administration; taxes; licensing and regulatory fees; contribution to reserves; risk margin; cost of capital and other operational costs associated with the managed care organization's provision of covered services to enrollees;

(4) consider the value of cost-sharing for rate development purposes, regardless of whether the managed care organization imposes the cost-sharing on the enrollee or the cost-sharing is collected by the provider;

(5) make appropriate and reasonable adjustments to account for changes to the base data, programmatic changes, changes to nonbenefit components, and any other adjustment necessary to establish actuarially sound rates. Each adjustment must reasonably support the development of an accurate base data set for purposes of rate setting, reflect the health status of the enrolled population, and be developed in accordance with generally accepted actuarial principles and practices;

(6) consider the managed care organization's past medical loss ratio in the development of the capitation rates and consider the projected medical loss ratio; and

(7) select a prospective or retrospective risk adjustment methodology that must be developed in a budget-neutral manner consistent with generally accepted actuarial principles and practices.

(b) The base data must be derived from the medical assistance population or, if data on the medical assistance population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to the medical assistance population. Data must be in accordance with actuarial standards for data quality and an explanation of why that specific data is used must be provided in the rate certification. If the commissioner is unable to base the rates on data that are within the three most recent and complete years before the rating period, the commissioner may request an approval from the Centers for Medicare and Medicaid Services for an exception. The request must describe why an exception is necessary and describe the actions that the commissioner intends to take to comply with the request.

Subd. 4. **Special contract requirements related to payment.** (a) If the commissioner uses risk-sharing mechanisms, including reinsurance, risk corridors, or stop-loss limits, the risk-sharing mechanism must be described in the contract, and must be developed according to the rate development standards and generally accepted actuarial principles and practices.

(b) The commissioner may utilize incentive payment arrangements in managed care organization contracts. Any incentive arrangement utilized by the commissioner must be made available to all managed care organizations under contract with the commissioner under the same terms of performance. The payment must not exceed 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement and must be actuarially sound. For all incentive arrangements the contract must state that the arrangement is:

(1) for a fixed period of time and performance is measured during the rating period in which the incentive arrangement is applied;

(2) not renewed automatically; and

(3) associated with specified activities, targets, performance measures, or quality-based outcomes in the quality strategy described under section 256B.6927.

The incentive payment arrangement must not condition a managed care organization's participation in the incentive arrangement upon entering into or adhering to an intergovernmental transfer agreement.

(c) The commissioner may utilize withhold arrangements in managed care organization contracts. Any withhold arrangement utilized by the commissioner must be applied to all managed care organizations under contract with the commissioner under the same terms of performance. Any withhold arrangement must ensure that the capitation payment minus any portion of the withheld funds that is not reasonably achievable is actuarially sound. The total amount of the withheld funds, achievable or not, must be reasonable and must take into consideration each managed care organization's financial operating needs, accounting for the size and characteristics of the populations covered under the contract, as well as the managed care organization's capital reserves, as measured by the risk based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required by Code of Federal Regulations, part 42, section 438.7, paragraph (b), clause (6). For all withhold arrangements, the contract must state that the arrangement is:

(1) for a fixed period of time and performance is measured during the rating period in which the withhold arrangement is applied;

(2) not renewed automatically; and

(3) associated with specified activities, targets, performance measures, or quality-based outcomes in the state's quality strategy.

The withhold payment arrangement must not condition a managed care organization's participation in the withhold arrangement upon entering into or adhering to an intergovernmental transfer agreement.

Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner shall not direct managed care organizations expenditures under the managed care contract, except in the following situations:

(1) implementation of a value-based purchasing model for provider reimbursement, including pay-for-performance arrangements, bundled payments, or other service payments intended to recognize value or outcomes over volume of services;

(2) participation in a multipayer or medical assistance-specific delivery system reform or performance improvement initiative; or

(3) implementation of a minimum or maximum fee schedule, or a uniform dollar or percentage increase for network providers that provide a particular service. The maximum

fee schedule must allow the managed care organization the ability to reasonably manage risk and provide discretion in accomplishing the goals of the contract.

(b) Any managed care contract that directs managed care organization expenditures as permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial soundness and generally accepted actuarial principles and practices; and have written approval from the Centers for Medicare and Medicaid Services before implementation. To obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

(1) is based on the utilization and delivery of services;

(2) directs expenditures equally, using the same terms of performance for a class of providers providing service under the contract;

(3) is intended to advance at least one of the goals and objectives in the commissioner's quality strategy;

(4) has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals in the commissioner's quality strategy;

(5) does not condition network provider participation on the network provider entering into or adhering to an intergovernmental transfer agreement; and

(6) is not renewed automatically.

(c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the commissioner shall:

(1) make participation in the value-based purchasing model, special delivery system reform, or performance improvement initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the model, reform, or initiative; and

(2) use a common set of performance measures across all payers and providers.

(d) The commissioner shall not set the amount or frequency of the expenditures or recoup from the managed care organization any unspent funds allocated for these arrangements.

Subd. 6. **Monthly capitation payments for placements in institutions of mental disease.** The commissioner may make a monthly capitation payment to a managed care organization for an enrollee under the age of 65 receiving treatment for psychiatric or substance use disorder in an institution for mental diseases in accordance with Code of Federal Regulations, part 42, section 438.6, paragraph (e).

Subd. 7. **Rate certification submission.** (a) The commissioner shall submit the rate certifications to the Centers for Medicare and Medicaid Services for review and approval at the same time as the managed care contracts. The rate certification must satisfy Code of Federal Regulations, part 42, section 438.7, paragraph (b), and must include:

(1) base data used in the rate setting process;

(2) trend, including changes in the utilization and the price of services;

(3) the nonbenefit component of the rate;

(4) any adjustments;

(5) the prospective and retrospective risk adjustment methodology; and

(6) any special contract provisions related to payment.

(b) The commissioner, through the state's actuary, must certify the final capitation rates paid per rate cell under each contract and document the underlying data, assumptions and methodologies.

(c) The commissioner may pay a managed care organization a capitation rate under a managed care contract that is different than the capitation rate paid to another managed care organization, if each capitation rate per rate cell that is paid is independently developed and set in accordance with Code of Federal Regulations, part 42, sections 438.4, 438.5, 438.6, and 438.8. The commissioner may increase or decrease the capitation rate per rate cell in accordance with Code of Federal Regulations, part 42, sections 438.4, paragraph (b), clause (4), and 438.7, paragraph (c), up to 1.5 percent without submitting a revised rate certification.

(d) If the commissioner determines that a retroactive adjustment to the capitation rate is necessary, the retroactive adjustment must be supported by a rationale for the adjustment and the data. Assumptions and methodologies used to develop the adjustment must be described with enough detail to allow the Centers for Medicare and Medicaid Services or an actuary to determine the reasonableness of the adjustment. Any retroactive adjustments must be certified by an actuary in a revised rate certification and submitted to the Centers for Medicare and Medicaid Services for approval as a contract amendment. All adjustments are subject to timely federal claim filing requirements.

(e) The commissioner shall, upon request from the Centers for Medicare and Medicaid Services, provide additional information if the Centers for Medicare and Medicaid Services determines the information is pertinent to certification approval. The commissioner shall identify whether the additional information shall be provided by the commissioner, the actuary, or another party.

Subd. 8. **Medical loss ratio.** (a) The commissioner shall require that each managed care organization calculate and submit to the commissioner a medical loss ratio report for each contract year. The calculation of the medical loss ratio in the medical loss ratio reporting year must be the ratio of the numerator to the denominator. The numerator must be the sum of the managed care organization's incurred claims, the managed care organization's expenditures for activities that improve health care quality, and fraud prevention activities. The denominator must be calculated as the managed care organization's adjusted premium revenue minus the managed care organization's federal, state, and local taxes and licensing and regulatory fees identified in Code of Federal Regulations, part 42, section 438.8, paragraph (f), clause (3). The total amount of the denominator for a managed care organization that is assumed by another managed care organization must be reported by the assuming managed care organization for the entire medical loss ratio reporting year. The managed care organization must aggregate the data for all eligibility groups covered under the contract, unless the commissioner requires separate reporting and a separate medical loss ratio calculation for specific populations.

(b) Incurred claims must be identified by the expenditures, liabilities, reserves, deductions, and exclusions in accordance with Code of Federal Regulations, part 42, section 438.8, paragraph (e), clause (2).

(c) Activities that improve health care quality must be in one category in accordance with Code of Federal Regulations, part 42, section 438.8, paragraph (e), clause (3).

(d) Fraud prevention activities, including managed care organization expenditures on activities related to fraud prevention must be identified in accordance with Code of Federal Regulations, part 45, section 158.

(e) Premium revenue must include capitation payments; onetime payments for specific life events of enrollees; other payments to the managed care organization in accordance with Code of Federal Regulations, part 42, section 438.6, paragraph (b), clause (3); unpaid cost-sharing amounts; and changes to unearned premium reserves, net payments, and receipts related to risk-sharing mechanisms.

(f) When calculating the medical loss ratio, each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be

reported on a pro rata basis. Expenses must be allocated using the methods described in Code of Federal Regulations, part 42, section 438.8, paragraph (g), clause (2).

(g) The commissioner may require the managed care organization to provide a remittance if the medical loss ratio for the medical loss ratio reporting year does not meet the minimum medical loss ratio standard of 85 percent, or if applicable, a higher ratio mandated by the commissioner.

Subd. 9. **Reports.** (a) The commissioner shall require each managed care organization to submit a report to the commissioner for each medical loss ratio reporting year that includes the information identified in Code of Federal Regulations, part 42, section 438.8, paragraph (k). The report must be submitted within 12 months of the end of each medical loss ratio reporting year. The managed care organization must require any third-party vendor providing claims adjudication to provide all underlying data associated with medical loss ratio reporting to the managed care organization within 180 days of the end of the medical loss ratio reporting year or within 30 days of being requested by the managed care organization to calculate and validate the accuracy of medical loss ratio reporting. The managed care organization must include with the medical loss ratio report an attestation as to the accuracy of the calculation of the medical loss ratio.

(b) The commissioner shall annually submit to the Centers for Medicare and Medicaid Services a summary description of the reports received from the managed care organizations in accordance with Code of Federal Regulations, part 42, section 438.8, paragraph (k), along with the rate certification required under subdivision 7. At a minimum, the summary description must include for the medical loss ratio report reporting year, the amount of the numerator, the amount of the denominator, the medical loss ratio percentage achieved, the number of member months, and any remittances owed. If through the contract the commissioner requires the managed care organization to pay remittances for not meeting the minimum medical loss ratio, the commissioner must reimburse the Centers for Medicare and Medicaid Services the federal share that reflects any differences in the federal matching rate. If a remittance is owed, the commissioner shall submit with the required report a separate report describing the methodology used to determine the state and federal shares of the remittance.

(c) If the commissioner makes a retroactive change to the capitation payments for a medical loss ratio reporting year for which the report was already submitted to the commissioner, the managed care organization shall recalculate the medical loss ratio for that year and submit a new report meeting the reporting requirements under paragraph (a).

(d) The commissioner may exempt a newly contracted managed care organization from calculating and reporting the medical loss ratio for the first year of the managed care organization's operation as required under this subdivision. If a managed care organization is excluded, the managed care organization must comply with the requirements of this section during the next medical loss ratio reporting year.

ARTICLE 16

CHILD CARE DEVELOPMENT BLOCK GRANT COMPLIANCE

Section 1. Minnesota Statutes 2016, section 245A.04, subdivision 4, is amended to read:

Subd. 4. **Inspections; waiver.** (a) Before issuing an initial license, 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; ~~and~~

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

(5) 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) is not required prior to issuing an initial license under subdivision 7. If the commissioner issues an initial license under subdivision 7, these requirements must be completed within one year after the issuance of an initial license.

(c) 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.

(d) No later than November 19, 2017, the commissioner shall make publicly available on the department's Web site 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. This section is effective August 1, 2017.

Sec. 2. Minnesota Statutes 2016, section 245A.09, subdivision 7, is amended to read:

Subd. 7. **Regulatory methods.** (a) Where appropriate and feasible the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include:

(1) expansion of the types and categories of licenses that may be granted;

(2) when the standards of another state or federal governmental agency or an independent accreditation body have been shown to require the same standards, methods, or alternative methods to achieve substantially the same intended outcomes as the licensing standards, the commissioner shall consider compliance with the governmental or accreditation standards to be equivalent to partial compliance with the licensing standards; and

(3) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.

(b) If the commissioner accepts accreditation as documentation of compliance with a licensing standard under paragraph (a), the commissioner shall continue to investigate complaints related to noncompliance with all licensing standards. The commissioner may take a licensing action for noncompliance under this chapter and shall recognize all existing appeal rights regarding any licensing actions taken under this chapter.

(c) The commissioner shall work with the commissioners of health, public safety, administration, and education in consolidating duplicative licensing and certification rules and standards if the commissioner determines that consolidation is administratively feasible, would significantly reduce the cost of licensing, and would not reduce the protection given to persons receiving services in licensed programs. Where administratively feasible and appropriate, the commissioner shall work with the commissioners of health, public safety, administration, and education in conducting joint agency inspections of programs.

(d) The commissioner shall work with the commissioners of health, public safety, administration, and education in establishing a single point of application for applicants who are required to obtain concurrent licensure from more than one of the commissioners listed in this clause.

(e) Unless otherwise specified in statute, the commissioner may conduct routine inspections biennially.

(f) For a licensed child care center, the commissioner shall conduct one unannounced licensing inspection at least annually.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 3. Minnesota Statutes 2016, section 245A.10, subdivision 2, is amended to read:

Subd. 2. **County fees for background studies and licensing inspections.** (a) Before the implementation of NETStudy 2.0, for purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed $100 annually. A county agency may also charge a license fee to an applicant or license holder not to exceed $50 for a one-year license or $100 for a two-year license.

(b) Before the implementation of NETStudy 2.0, a county agency may charge a fee to a legal nonlicensed child care provider or applicant for authorization to recover the actual cost of background studies completed under section 119B.125, but in any case not to exceed $100 annually.

(c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area;

(3) for new providers; or

(4) for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an installment basis for up to one year. If the provider is receiving child care assistance payments from the state, the provider may have the fees under paragraph (a) or (b) deducted from the child care assistance payments for up to one year and the state shall reimburse the county for the county fees collected in this manner.

(e) For purposes of adult foster care and child foster care licensing, and licensing the physical plant of a community residential setting, under this chapter, a county agency may charge a fee to a corporate applicant or corporate license holder to recover the actual cost of licensing inspections, not to exceed $500 annually.

(f) Counties may elect to reduce or waive the fees in paragraph (e) under the following circumstances:

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area; or

(3) for new providers.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 4. Minnesota Statutes 2016, section 245A.14, is amended by adding a subdivision to read:

Subd. 15. **Parental access in child care programs.** An enrolled child's parent or legal guardian must be allowed access to the parent's or legal guardian's child any time while the child is in care.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 5. Minnesota Statutes 2016, 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.

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 ~~day~~ child care programs, the commissioner ~~may authorize~~ shall require a county agency to conduct one unannounced licensing ~~reviews every two years after a licensee has had at least one annual~~ 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, any licensing correction order issued; and

(2) any death, serious injury, or determination of substantiated maltreatment.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 6. Minnesota Statutes 2016, section 245A.16, is amended by adding a subdivision to read:

Subd. 7. **Family child care licensing oversight.** Only county staff trained by the commissioner on the family child care licensing standards in this chapter and Minnesota Rules, chapter 9502, shall perform family child care licensing functions under subdivision 1. Training must occur within 90 days of a staff person's employment.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 7. Minnesota Statutes 2016, section 245A.40, is amended by adding a subdivision to read:

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.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 8. **[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 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 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.

(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.

Sec. 9. **[245A.51] FAMILY CHILD CARE HEALTH AND SAFETY REQUIREMENTS.**

Subdivision 1. **Allergy prevention and response.** (a) Before admitting a child for care, the license holder must obtain information about any known allergy from the child's parent or legal guardian. The license holder must maintain current allergy information in each child's record. The allergy information must include 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 child's allergy information must be documented on a form approved by the commissioner, readily available to all caregivers, and reviewed annually by the license holder and each caregiver.

Subd. 2. **Handling and disposal of bodily fluids.** The licensed family child care provider 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 as described in section 245A.148;

(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; and

(4) the license holder must have the following bodily fluid disposal supplies available: disposable gloves, disposal bags, and eye protection.

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.

(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 August 1, 2017.

Sec. 10. Minnesota Statutes 2016, section 245C.02, is amended by adding a subdivision to read:

Subd. 6a. **Child care staff person.** "Child care staff person" means an individual other than an individual who is related to all children for whom child care services are provided and:

(1) who is employed by a child care provider for compensation;

(2) whose activities involve the care or supervision of a child for a child care provider or unsupervised access to a child who is cared for or supervised by a child care provider; or

(3) an individual 13 years of age or older residing in a licensed family child care home or legal nonlicensed child care program.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 11. Minnesota Statutes 2016, 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;

(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; ~~and~~

(7) all ~~managerial officials~~ controlling individuals as defined ~~under~~ in section 245A.02, subdivision 5a~~.~~; and

(8) child care staff persons as defined in section 245C.02, subdivision 6a.

(b) Paragraph (a), clauses (5) and (6), apply to legal nonlicensed child care and certified license-exempt child care programs.

~~(b)~~ (c) For family child foster care settings, 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.

EFFECTIVE DATE. This section is effective when the Department of Human Services implements NETStudy 2.0 or October 1, 2017, whichever is later. The commissioner of human services shall notify the revisor of statutes when the department implements NETStudy 2.0.

Sec. 12. Minnesota Statutes 2016, section 245C.03, is amended by adding a subdivision to read:

Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner shall conduct background studies on an individual required under sections 119B.125 and 245G.10 to complete a background study under this chapter.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 13. Minnesota Statutes 2016, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, including a child care staff person as defined in section 245C.02, subdivision 6a, in a family child care program, licensed child care center, certified license-exempt child care center, or legal nonlicensed child care provider, on a schedule determined by the commissioner. The background study must include submission of fingerprints for a national criminal history record check and a review of the information under section 245C.08. A background study for a child care program must be repeated within five years from the most recent study conducted under this paragraph.

(c) At reapplication ~~for a license~~ for a family child care~~.~~ license:

(1) for a background study affiliated with a licensed family child care center or legal nonlicensed child care provider, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed under section 245C.05, subdivision 5;

(2) the county agency shall verify the information received under clause (1) and forward the information to the commissioner to complete the background study; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08.

~~(c)~~ (d) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:

(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(3) the last study of the individual was conducted on or after October 1, 1995.

~~(d)~~ (e) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster care license holder. The county or private agency

shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5. The background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

~~(e)~~ (f) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family adult day services and with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 119B: (1) the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) ~~and~~, (b), and (d), for background studies conducted by the commissioner for all family adult day services ~~and~~, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 119B; (2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and (3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

~~(f)~~ (g) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(g)~~ (h) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the 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.

~~(h)~~ (i) For purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results.

~~(i)~~ (j) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

(k) A repeat background study at the time of license renewal is not required if the family child care substitute caregiver's background study was completed by the commissioner on or after October 1, 2017, and the substitute caregiver is on the license holder's active roster in NETStudy 2.0.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 14. Minnesota Statutes 2016, section 245C.04, subdivision 8, is amended to read:

Subd. 8. **Current or prospective contractors serving multiple family child care license holders.** (a) Before the implementation of NETStudy 2.0, current or prospective contractors who are required to have a background study under section 245C.03, subdivision 1, who provide services for multiple family child care license holders in a single county, and will have direct contact with children served in the family child care setting are required to have only one background study which is transferable to all family child care programs in that county if:

(1) the county agency maintains a record of the contractor's background study results which verify the contractor is approved to have direct contact with children receiving services;

(2) the license holder contacts the county agency and obtains notice that the current or prospective contractor is in compliance with background study requirements and approved to have direct contact; and

(3) the contractor's background study is repeated every two years.

(b) For a family child care license holder operating under NETStudy 2.0, the license holder's active roster shall be the system used to document when a background study subject is affiliated with the license holder.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 15. Minnesota Statutes 2016, section 245C.05, subdivision 2b, is amended to read:

Subd. 2b. **County agency to collect and forward information to commissioner.** (a) For background studies related to all family adult day services and to adult foster care when the adult foster care license holder resides in the adult foster care residence, the county agency must collect the information required under subdivision 1 and forward it to the commissioner.

(b) Upon implementation of NETStudy 2.0, for background studies related to family child care and legal nonlicensed child care authorized under chapter 119B, the county agency must collect the information required under subdivision 1 and provide the information to the commissioner.

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

Sec. 16. Minnesota Statutes 2016, 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.

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

Sec. 17. Minnesota Statutes 2016, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints and photograph.** (a) Before the implementation of NETStudy 2.0, except as provided in paragraph (c), for any background study completed under this chapter, when the commissioner has reasonable cause to believe that further pertinent information may exist on the subject of the background study, the subject shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

(b) Before the implementation of NETStudy 2.0, for purposes of requiring fingerprints, the commissioner has reasonable cause when, but not limited to, the:

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

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

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

(c) Notwithstanding paragraph (d), for background studies conducted by the commissioner for child foster care, 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.

(d) For background studies initiated on or after the implementation of NETStudy 2.0, 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). The fingerprints shall not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or the commissioner, but will be retained by the Federal Bureau of Investigation. 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.

(e) When specifically required by law, fingerprints collected under this section must be submitted for a national criminal history record check.

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

Sec. 18. Minnesota Statutes 2016, section 245C.05, subdivision 7, is amended to read:

Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or corrections agent shall notify the commissioner of an individual's conviction if the individual:

(1) has been affiliated with a program or facility regulated by the Department of Human Services or Department of Health, a facility serving children or youth licensed by the Department of Corrections, or any type of home care agency or provider of personal care assistance services within the preceding year; and

(2) has been convicted of a crime constituting a disqualification under section 245C.14.

(b) For the purpose of this subdivision, "conviction" has the meaning given it in section 609.02, subdivision 5.

(c) The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this subdivision and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents.

(d) The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes ~~will~~ shall be reported to the commissioner by the corrections system.

(e) A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this subdivision.

(f) Upon receipt of disqualifying information, the commissioner shall provide the notice required under section 245C.17, as appropriate, to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual.

(g) This subdivision does not apply to family child care programs or legal nonlicensed child care programs for individuals whose background study was completed in NETStudy 2.0.

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

Sec. 19. Minnesota Statutes 2016, section 245C.08, subdivision 1, is amended to read:

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

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

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

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

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

(5) except as provided in clause (6), information ~~from the national crime information system~~ received as a result of submission of fingerprints for a national criminal history record check, when the commissioner has reasonable cause as defined under section 245C.05, subdivision 5, or as required under section 144.057, subdivision 1, clause (2); ~~and~~

(6) for a background study related to a child foster care application for licensure, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, 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) ~~information from national crime information databases,~~ when the background study subject is 18 years of age or older~~.~~, information received following submission of fingerprints for a national criminal history record check; 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 a name and date-of-birth search of the National Sex Offender Public Web site.

(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. This section is effective October 1, 2017.

Sec. 20. Minnesota Statutes 2016, section 245C.08, subdivision 2, is amended to read:

Subd. 2. **Background studies conducted by a county agency for family child care.** (a) Before the implementation of NETStudy 2.0, for a background study conducted by a county agency for family child care services, the commissioner shall review:

(1) information from the county agency's record of substantiated maltreatment of adults and the maltreatment of minors;

(2) information from juvenile courts as required in subdivision 4 for:

(i) individuals listed in section 245C.03, subdivision 1, paragraph (a), who are ages 13 through 23 living in the household where the licensed services will be provided; and

(ii) any other individual listed under section 245C.03, subdivision 1, when there is reasonable cause; and

(3) information from the Bureau of Criminal Apprehension.

(b) If the individual has resided in the county for less than five years, the study shall include the records specified under paragraph (a) for the previous county or counties of residence for the past five years.

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

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

Sec. 21. Minnesota Statutes 2016, section 245C.08, subdivision 4, is amended to read:

Subd. 4. **Juvenile court records.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review records from the juvenile courts for an individual studied under section 245C.03, subdivision 1, paragraph (a), when the commissioner has reasonable cause.

(b) For a background study conducted by a county agency for family child care before the implementation of NETStudy 2.0, the commissioner shall review records from the juvenile courts for individuals listed in section 245C.03, subdivision 1, who are ages 13 through 23 living in the household where the licensed services will be provided. The commissioner shall also review records from juvenile courts for any other individual listed under section 245C.03, subdivision 1, when the commissioner has reasonable cause.

(c) The juvenile courts shall help with the study by giving the commissioner existing juvenile court records relating to delinquency proceedings held on individuals described in section 245C.03, subdivision 1, paragraph (a), when requested pursuant to this subdivision.

(d) For purposes of this chapter, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

(e) Juvenile courts shall provide orders of involuntary and voluntary termination of parental rights under section 260C.301 to the commissioner upon request for purposes of conducting a background study under this chapter.

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

Sec. 22. Minnesota Statutes 2016, section 245C.09, is amended by adding a subdivision to read:

Subd. 3. **False statement in connection with a background study.** An individual shall be disqualified for knowingly making a materially false statement in connection with a background study.

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

Sec. 23. Minnesota Statutes 2016, section 245C.10, subdivision 9, is amended to read:

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care ~~and~~ for certified license-exempt child care centers, licensed child care centers, and legal nonlicensed care authorized under chapter 119B, and licensed family child care, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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

Sec. 24. Minnesota Statutes 2016, section 245C.10, is amended by adding a subdivision to read:

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than $30 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Sec. 25. Minnesota Statutes 2016, section 245C.11, subdivision 3, is amended to read:

Subd. 3. **Criminal history data.** County agencies shall have access to the criminal history data in the same manner as county licensing agencies under this chapter for purposes of background studies completed before the implementation of NETStudy 2.0 by county agencies on legal nonlicensed child care providers to determine eligibility for child care funds under chapter 119B.

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

Sec. 26. Minnesota Statutes 2016, section 245C.15, is amended to read:

245C.15 DISQUALIFYING CRIMES OR CONDUCT.

Subdivision 1. **Permanent disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) regardless of how much time has passed since the discharge of the sentence imposed, if any, for the offense; and (2) unless otherwise specified, regardless of the level of the offense, the individual has committed any of the following offenses: sections 243.166 (violation of predatory offender registration law); 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20

(manslaughter in the first degree); 609.205 (manslaughter in the second degree); a felony offense under 609.221 or 609.222 (assault in the first or second degree); a felony conviction under section 609.223 or 609.2231 (assault in the third or fourth degree); a felony offense under sections 609.2242 and 609.2243 (domestic assault), spousal abuse, child abuse or neglect, or a crime against children; 609.2247 (domestic assault by strangulation); any conviction under section 609.224 or 609.2242 (assault in the fifth degree or domestic assault) for an offense committed by an adult against a child; 609.228 (great bodily harm caused by distribution of drugs); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.282 (labor trafficking); 609.322 (solicitation, inducement, and promotion of prostitution); 609.324, subdivision 1 (other prohibited acts); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); a felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); a felony conviction under section 609.562 or 609.563 (arson in the second or third degree); 609.66, subdivision 1e (drive-by shooting); 609.746, subdivision 1, paragraph (e) (interference with privacy involving a minor); 609.749, subdivision 3, 4, or 5 (felony-level stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); 617.23, subdivision 2, clause (1), or subdivision 3, clause (1) (indecent exposure involving a minor); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors); a felony-level conviction for a crime against a child or involving child pornography. For a background study required for family child care, child care centers, and legal nonlicensed child care authorized under chapter 119B, an individual is permanently disqualified for a conviction at any level for child abuse or child neglect.

(b) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14.

(c) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraph (a), permanently disqualifies the individual under section 245C.14.

(d) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(e) If the individual studied commits one of the offenses listed in paragraph (a) that is specified as a felony-level only offense, but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified, but the disqualification look-back period for the offense is the period applicable to gross misdemeanor or misdemeanor offenses.

(f) An individual shall be disqualified as long as the individual is registered, or required to be registered, on a state sex offender registry or repository or the National Sex Offender Registry.

Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a felony-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.165 (felon ineligible to possess firearm); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); a preponderance of evidence of 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal abuse of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521 (possession of shoplifting gear); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen

property); 609.535 (issuance of dishonored checks); a preponderance of evidence of 609.562 (arson in the second degree); a preponderance of evidence of 609.563 (arson in the third degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 624.713 (certain persons not to possess firearms); chapter 152 (drugs; controlled substance); or Minnesota Statutes 2012, section 609.21; or a felony-level conviction involving alcohol or drug use.

(b) An individual is disqualified under section 245C.14 if less than 15 years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than 15 years has passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or subdivision 3.

(d) An individual is disqualified under section 245C.14 if less than 15 years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses listed in paragraph (a).

(e) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified but the disqualification look-back period for the offense is the period applicable to the gross misdemeanor or misdemeanor disposition.

(f) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a gross misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth degree); 609.224 (assault in the fifth degree not by an adult against a minor); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault not by an adult against a minor); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); repeat gross-misdemeanor level offenses under 609.746 (interference with privacy); 609.749, subdivision 2 (stalking); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01, subdivision 14.

(b) An individual is disqualified under section 245C.14 if less than ten years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than ten years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

(d) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a misdemeanor disposition, the individual is disqualified but the disqualification lookback period for the offense is the period applicable to misdemeanors.

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231 (assault in the fourth degree); 609.224 (assault in the fifth degree not by an adult against a minor); 609.2242 (domestic assault not by an adult against a minor); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter, telegram, or package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic Abuse Act).

(b) An individual is disqualified under section 245C.14 if less than seven years has passed since a determination or disposition of the individual's:

(1) failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

(2) substantiated serious or recurring maltreatment of a minor under section 626.556, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under section 626.556 or 626.557 for which: (i) there is a preponderance of evidence that the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

(c) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes.

(d) An individual is disqualified under section 245C.14 if less than seven years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraphs (a) and (b).

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(f) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual was disqualified under section 256.98, subdivision 8.

Subd. 5. **Mental illness.** The commissioner may not disqualify an individual subject to a background study under this chapter because that individual has, or has had, a mental illness as defined in section 245.462, subdivision 20.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 27. Minnesota Statutes 2016, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside; and

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.556 or 626.557.

(d) This section does not apply to a background study related to an initial application for a child foster care license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1.

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 28. Minnesota Statutes 2016, section 245C.17, subdivision 6, is amended to read:

Subd. 6. **Notice to county agency.** For studies on individuals related to a license to provide adult foster care and family adult day services and, effective upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also provide a notice of the background study results to the county agency that initiated the background study.

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

Sec. 29. Minnesota Statutes 2016, section 245C.21, subdivision 1, is amended to read:

Subdivision 1. **Who may request reconsideration.** An individual who is the subject of a disqualification may request a reconsideration of the disqualification pursuant to this section. The individual must submit the request for reconsideration to the commissioner in writing.

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

Sec. 30. Minnesota Statutes 2016, 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 ~~(g)~~ (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) 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 October 1, 2017.

Sec. 31. Minnesota Statutes 2016, section 245C.22, subdivision 7, is amended to read:

Subd. 7. **Classification of certain data.** (a) Notwithstanding section 13.46, except as provided in paragraph (f), upon setting aside a disqualification under this section, the identity of the disqualified individual who received the set-aside and the individual's disqualifying characteristics are public data if the set-aside was:

(1) for any disqualifying characteristic under section 245C.15, except a felony-level conviction for a drug-related offense within the past five years, when the set-aside relates to a child care center or a family child care provider licensed under chapter 245A, certified license-exempt child care center, or legal nonlicensed family child care center; or

(2) for a disqualifying characteristic under section 245C.15, subdivision 2.

(b) Notwithstanding section 13.46, upon granting a variance to a license holder under section 245C.30, the identity of the disqualified individual who is the subject of the variance, the individual's disqualifying characteristics under section 245C.15, and the terms of the variance are public data, except as provided in paragraph (c), clause (6), when the variance:

(1) is issued to a child care center or a family child care provider licensed under chapter 245A; or

(2) relates to an individual with a disqualifying characteristic under section 245C.15, subdivision 2.

(c) The identity of a disqualified individual and the reason for disqualification remain private data when:

(1) a disqualification is not set aside and no variance is granted, except as provided under section 13.46, subdivision 4;

(2) the data are not public under paragraph (a) or (b);

(3) the disqualification is rescinded because the information relied upon to disqualify the individual is incorrect;

(4) the disqualification relates to a license to provide relative child foster care. As used in this clause, "relative" has the meaning given it under section 260C.007, subdivision 26b or 27; ~~or~~

(5) the disqualified individual is a household member of a licensed foster care provider and:

(i) the disqualified individual previously received foster care services from this licensed foster care provider;

(ii) the disqualified individual was subsequently adopted by this licensed foster care provider; and

(iii) the disqualifying act occurred before the adoption; or

(6) a variance is granted to a child care center or family child care license holder for an individual's disqualification that is based on a felony-level conviction for a drug-related offense that occurred within the past five years.

(d) Licensed family child care providers and child care centers must provide notices as required under section 245C.301.

(e) Notwithstanding paragraphs (a) and (b), the identity of household members who are the subject of a disqualification related set-aside or variance is not public data if:

(1) the household member resides in the residence where the family child care is provided;

(2) the subject of the set-aside or variance is under the age of 18 years; and

(3) the set-aside or variance only relates to a disqualification under section 245C.15, subdivision 4, for a misdemeanor-level theft crime as defined in section 609.52.

(f) When the commissioner has reason to know that a disqualified individual has received an order for expungement for the disqualifying record that does not limit the commissioner's access to the record, and the record was opened or exchanged with the commissioner for purposes of a background study under this chapter, the data that would otherwise become public under paragraph (a) or (b) remain private data.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 32. Minnesota Statutes 2016, section 245C.23, is amended to read:

245C.23 COMMISSIONER'S RECONSIDERATION NOTICE.

Subdivision 1. **Disqualification that is rescinded or set aside.** (a) If the commissioner rescinds or sets aside a disqualification, the commissioner shall notify the applicant, license holder, or other entity in writing or by electronic transmission of the decision.

(b) In the notice from the commissioner that a disqualification has been rescinded, the commissioner must inform the applicant, license holder, or other entity that the information relied upon to disqualify the individual was incorrect.

(c) Except as provided in ~~paragraph~~ paragraphs (d) and (e), in the notice from the commissioner that a disqualification has been set aside, the commissioner must inform the applicant, license holder, or other entity of the reason for the individual's disqualification and that information about which factors under section 245C.22, subdivision 4, were the basis of the decision to set aside the disqualification are available to the license holder upon request without the consent of the background study subject.

(d) When the commissioner has reason to know that a disqualified individual has received an order for expungement for the disqualifying record that does not limit the commissioner's access to the record, and the record was opened or exchanged with the commissioner for purposes of a background study under this chapter, the information provided under paragraph (c) must only inform the applicant, license holder, or other entity that the disqualifying criminal record is sealed under a court order.

(e) The notification requirements in paragraph (c) do not apply when the set aside is granted to an individual related to a background study for a licensed child care center, certified license-exempt child care center, or family child care license holder, or for a legal nonlicensed child care provider authorized under chapter 119B, and the individual is disqualified for a felony-level conviction for a drug-related offense that occurred within the past five years. The notice that the individual's disqualification is set aside must inform the applicant, license holder, or legal nonlicensed child care provider that the disqualifying criminal record is not public.

Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The commissioner shall notify the license holder of the disqualification and order the license holder to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder if:

(1) the individual studied does not submit a timely request for reconsideration under section 245C.21;

(2) the individual submits a timely request for reconsideration, but the commissioner does not set aside the disqualification for that license holder under section 245C.22, unless the individual has a right to request a hearing under section 245C.27, 245C.28, or 256.045;

(3) an individual who has a right to request a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does not request a hearing within the specified time; or

(4) an individual submitted a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the order remains in effect pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(c) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was not previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous direct supervision when providing direct contact services, the commissioner shall order the individual to remain under continuous

direct supervision pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(d) For background studies related to child foster care, the commissioner shall also notify the county or private agency that initiated the study of the results of the reconsideration.

(e) For background studies related to family child care, legal nonlicensed child care, adult foster care, and family adult day services, the commissioner shall also notify the county that initiated the study of the results of the reconsideration.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 33. Minnesota Statutes 2016, section 245C.24, subdivision 3, is amended to read:

Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home if: (1) less than ten years has passed since the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based on a preponderance of evidence determination under section 245C.14, subdivision 1, paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph (a), clause (1), and less than ten years has passed since the individual committed the act or admitted to committing the act, whichever is later; and (3) the individual has committed a violation of any of the following offenses: sections 609.165 (felon ineligible to possess firearm); criminal vehicular homicide or criminal vehicular operation causing death under 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding suicide or aiding attempted suicide); preponderance of evidence of felony violations under 609.223 or 609.2231 (assault in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns); 609.749, subdivision 2 (gross misdemeanor stalking); 152.021 or 152.022 (controlled substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree); 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of

residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree); 609.268 (injury or death of an unborn child in the commission of a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or displaying harmful material to minors); a felony-level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess firearms); or Minnesota Statutes 2012, section 609.21.

(b) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a) as each of these offenses is defined in Minnesota Statutes.

(c) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 34. Minnesota Statutes 2016, section 245C.25, is amended to read:

245C.25 CONSOLIDATED RECONSIDERATION OF MALTREATMENT DETERMINATION AND DISQUALIFICATION.

~~(a)~~ If an individual is disqualified on the basis of a determination of maltreatment under section 626.556 or 626.557, which was serious or recurring, and the individual requests reconsideration of the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and also requests reconsideration of the disqualification under section 245C.21, the commissioner shall consolidate the reconsideration of the maltreatment determination and the disqualification into a single reconsideration.

~~(b) For maltreatment and disqualification determinations made by county agencies, the county agency shall conduct the consolidated reconsideration. If the county agency has disqualified an individual on multiple bases, one of which is a county maltreatment~~

~~determination for which the individual has a right to request reconsideration, the county shall conduct the reconsideration of all disqualifications.~~

~~(c) If the county has previously conducted a consolidated reconsideration under paragraph (b) of a maltreatment determination and a disqualification based on serious or recurring maltreatment, and the county subsequently disqualifies the individual based on that determination, the county shall conduct the reconsideration of the subsequent disqualification. The scope of the subsequent disqualification shall be limited to whether the individual poses a risk of harm in accordance with section 245C.22, subdivision 4. If the commissioner subsequently disqualifies the individual in connection with a child foster care license based on the county's previous maltreatment determination, the commissioner shall conduct the reconsideration of the subsequent disqualification.~~

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 35. Minnesota Statutes 2016, 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 or license holder requests the variance and the disqualified individual provides written consent for the commissioner to disclose to the applicant 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 October 1, 2017.

Sec. 36. **[245G.01] DEFINITIONS.**

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given in this section.

Subd. 2. **Applicant.** "Applicant" means an individual or organization that is subject to certification under this chapter and that applied for but is not yet granted certification under this chapter.

Subd. 3. **Center operator or program operator.** "Center operator" or "program operator" means the person exercising supervision or control over the center's or program's operations, planning, and functioning. There may be more than one designated center operator or program operator.

Subd. 4. **Certification holder.** "Certification holder" means the individual or organization that is legally responsible for the operation of the center, and granted certification by the commissioner under this chapter.

Subd. 5. **Certified license-exempt child care center.** "Certified license-exempt child care center" means the commissioner's written authorization for a child care center excluded from licensure under section 245A.03, subdivision 2, paragraph (a), clause (5), (11) to (13), (15), (18), or (26), to register to receive child care assistance payments under chapter 119B.

Subd. 6. **Disinfecting.** "Disinfecting" means the use of a product capable of destroying or inactivating harmful germs, except bacterial spores, consistent with label directions on environmental surfaces including bathroom toilets and floors, diaper-changing surfaces, and surfaces exposed to blood or other bodily fluids.

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

Sec. 37. **[245G.02] WHO MUST BE CERTIFIED.**

A program that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause (5), (11) to (13), (15), (18), or (26), and is authorized to receive child care assistance payments under chapter 119B, must be a certified license-exempt child care center according to this section.

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

Sec. 38. **[245G.03] APPLICATION PROCEDURES.**

Subdivision 1. **Schedule.** The certification of license-exempt child care centers shall be implemented by September 30, 2017. Certification applications shall be received and processed on a phased-in schedule as determined by the commissioner.

Subd. 2. **Application submission.** The commissioner shall provide application instructions and information about the rules and requirements of other state agencies that

affect the applicant. The certification application must be submitted in a manner prescribed by the commissioner. The commissioner shall act on the application within 90 working days of receiving a completed application.

Subd. 3. **Incomplete applications.** When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the documents submitted do not meet certification requirements, the commissioner shall provide the applicant written notice that the application is incomplete or deficient. In the notice, the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is complete. An applicant's failure to submit a complete application after receiving notice from the commissioner is basis for certification denial.

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

Sec. 39. **[245G.04] COMMISSIONER'S RIGHT OF ACCESS.**

(a) When the commissioner is exercising the powers conferred by this chapter, whenever the center is in operation and the information is relevant to the commissioner's inspection or investigation, the commissioner must be given access to:

(1) the physical facility and grounds where the program is provided;

(2) documentation and records, including electronically maintained records;

(3) children served by the center; and

(4) staff and personnel records of current and former staff.

(b) The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment or a violation of a law or rule, or conducting an inspection. When conducting an inspection, the commissioner may request and shall receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or certification holder shall allow the commissioner, at the commissioner's expense, to photocopy, photograph, and make audio and video recordings during an inspection at the commissioner's expense.

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

Sec. 40. **[245G.05] MONITORING AND INSPECTIONS.**

(a) The commissioner must conduct an on-site inspection of a certified license-exempt child care center at least annually to determine compliance with the health, safety, and fire standards specific to a certified license-exempt child care center.

(b) No later than November 19, 2017, the commissioner shall make publicly available on the department's Web site the results of inspection reports for all certified centers including the number of deaths, serious injuries, and instances of substantiated child maltreatment that occurred in certified centers each year.

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

Sec. 41. **[245G.06] CORRECTION ORDER.**

Subdivision 1. **Correction order requirements.** If the applicant or certification holder failed to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule violated; and

(3) the time allowed to correct each violation.

Subd. 2. **Reconsideration request.** (a) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the part of the correction order that is allegedly erroneous. A request for reconsideration must be made in writing, postmarked, and sent to the commissioner within 20 calendar days after the applicant or certification holder received the correction order, and must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

(3) include documentation to support the allegation of error.

(b) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

Subd. 3. **Decertification following a correction order.** (a) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the

correction order, the commissioner may decertify the license-exempt center pursuant to section 245G.07.

(b) Nothing in this section prohibits the commissioner from decertifying a center according to section 245G.07.

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

Sec. 42. **[245G.07] DECERTIFICATION.**

(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.

(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.

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

Sec. 43. **[245G.08] STAFFING REQUIREMENTS.**

Subdivision 1. **Staffing requirements.** During hours of operation, a certified center must have a director or designee on site who is responsible for overseeing implementation of written policies relating to the management and control of the daily activities of the program, ensuring the health and safety of program participants, and supervising staff and volunteers.

Subd. 2. **Director qualifications.** The director must be 18 years of age or older and have completed at least 16 hours of training in any of the following topic areas: child development and learning; developmentally appropriate learning experiences; relationships with families; assessment, evaluation, and individualization; historical and contemporary development of early childhood education; professionalism; and health, safety, and nutrition.

Subd. 3. **Staff qualifications.** A staff person must be 16 years of age or older before providing direct, unsupervised care to a child.

Subd. 4. **Maximum group size.** (a) For a child six weeks old through 16 months old, the maximum group size shall be no more than eight children.

(b) For a child 16 months old through 33 months old, the maximum group size shall be no more than 14 children.

(c) For a child 33 months old through prekindergarten, a maximum group size shall be no more than 20 children.

(d) For a child in kindergarten through 13 years old, a maximum group size shall be no more than 30 children.

(e) The maximum group size applies at all times except during group activity coordination time not exceeding 15 minutes, during a meal, outdoor activity, field trip, nap and rest, and special activity including a film, guest speaker, indoor large muscle activity, or holiday program.

Subd. 5. **Ratios.** (a) The minimally acceptable staff-to-child ratios are:

six weeks old through 16 months old	1:4
16 months old through 33 months old	1:7
33 months old through prekindergarten	1:10
kindergarten through 13 years old	1:15

(b) Kindergarten includes a child of sufficient age to have attended the first day of kindergarten or who is eligible to enter kindergarten within the next four months.

(c) For mixed groups, the ratio for the age group of the youngest child applies.

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

Sec. 44. **[245G.10] BACKGROUND STUDIES.**

Subdivision 1. **Documentation.** (a) The applicant or certification holder must submit and maintain documentation of a completed background study for:

(1) each person applying for the certification;

(2) each person identified as a center operator or program operator as defined in section 245G.01, subdivision 5;

(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 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 subdivision 1, clause (1), 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.

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.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 45. **[245G.11] REPORTING.**

(a) The certification holder must 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 August 1, 2017.

Sec. 46. **[245G.12] FEES.**

The commissioner shall consult with stakeholders to develop an administrative fee to implement this chapter. By February 15, 2019, the commissioner shall provide recommendations on the amount of an administrative fee to the legislative committees with jurisdiction over health and human services policy and finance.

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

Sec. 47. **[245G.13] HEALTH AND SAFETY REQUIREMENTS.**

Subdivision 1. **Exclusion of sick children and infectious disease outbreak control.** (a) A certified center must supervise and isolate a child from other children in the program when a child becomes sick and immediately notify the sick child's parent or legal guardian.

(b) A certified center must post or give notice to the parent or legal guardian of an exposed child the same day the program is notified of a child's contagious reportable disease specified in Minnesota Rules, part 4605.7040, or scabies, impetigo, ringworm, or chicken pox.

Subd. 2. **Immunizations.** By a child's date of attendance, the certified center must maintain or have access to a record detailing the child's current immunizations or applicable exemption.

Subd. 3. **Administration of medication.** (a) A certified center that chooses to administer medicine must meet the requirements in this subdivision.

(b) The certified center must obtain written permission from the child's parent or legal guardian before administering prescription medicine, diapering product, sunscreen lotion, and insect repellent.

(c) The certified center must administer nonprescription medicine, diapering product, sunscreen lotion, and insect repellent according to the manufacturer's instructions unless provided written instructions by a licensed health professional to use a product differently.

(d) The certified center must obtain and follow written instructions from the prescribing health professional before administering prescription medicine. Medicine with the child's first and last name and current prescription information on the label is considered written instructions.

(e) The certified center must ensure all medicine is:

(1) kept in the medicine's original container with a legible label stating the child's first and last name;

(2) given only to the child whose name is on the label;

(3) not given after an expiration date on the label; and

(4) returned to the child's parent or legal guardian or destroyed, if unused.

(f) The certified center must document in the child's record the administration of medication, including the child's first and last name; the name of the medication or prescription number; the date, time, and dosage; and the name and signature of the person who administered the medicine. This documentation must be available to the child's parent or legal guardian.

(g) The certified center must store medicines, insect repellents, and diapering products according to directions on the original container.

Subd. 4. **Preventing and responding to allergies.** (a) Before admitting a child for care, the certified center must obtain documentation of any known allergies from the child's parent or legal guardian. The certified center must maintain current allergy information in each child's record. The allergy information must include:

(1) a description of the allergy, specific triggers, avoidance techniques, and symptoms of an allergic reaction; and

(2) procedures for responding to an allergic reaction, including medication, dosages, and a doctor's contact information.

(b) The certified center must inform staff of each child's current allergy information. At least annually and when a change is made to allergy-related information in a child's record, the certified center must inform staff of any change. Documentation that staff were informed of the child's current allergy information must be kept on site.

(c) A child's allergy information must be available at all times including on site, when on field trips, or during transportation. Food allergy information must be readily available to staff in the area where food is prepared and served to the child.

Subd. 5. **Building and physical premises; free of hazards.** (a) The certified center must document compliance with the State Fire Code by 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.

(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.

Subd. 6. **Transporting children.** (a) If a certified center chooses to transport a child, the certified center must ensure that the driver of the vehicle holds a valid driver's license, appropriate to the vehicle driven.

(b) If a certified center chooses to transport a child, the center must comply with all seat belt and child passenger restraint system requirements under sections 169.685 and 169.686.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 48. **[245G.14] TRAINING REQUIREMENTS.**

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.

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 staff persons and 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.

Subd. 3. **Abusive head trauma.** A certified center that cares for a child through four years of age must ensure that staff persons and 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.

Subd. 4. **Child development.** The certified center must ensure each staff person completes at least two hours of child development and learning training within 14 days of employment and annually thereafter. 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.

Subd. 5. **Orientation.** The certified center must ensure each staff person is trained at orientation on health and safety requirements in sections 245G.11, 245G.13, 245G.14, and 245G.15. The certified center must provide staff with an orientation within 14 days of employment. Before the completion of orientation, a staff person must be supervised while providing direct care to a child.

Subd. 6. **In service.** (a) The certified center must ensure each staff person is trained at least annually on health and safety requirements in sections 245G.11, 245G.13, 245G.14, and 245G.15.

(b) Each staff person must annually complete at least six hours of training. Training required under paragraph (a) may be used toward the hourly training requirements of this subdivision.

Subd. 7. **Documentation.** A certified center must document the date of a completed training required by this section in the personnel record of each staff person.

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

Sec. 49. **[245G.15] EMERGENCY PREPAREDNESS.**

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.

(c) The certification holder must have an emergency plan available for review upon request by the child's parent or legal guardian.

Subd. 2. **Staff person training.** The certification holder must train a staff person at orientation and at least once each calendar year on the emergency plan and document training in each personnel file. The certified center must conduct at least quarterly one evacuation drill and one shelter-in-place drill. The date and time of the drills must be documented.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 50. **[245G.16] PERSONNEL RECORD.**

The certification holder must maintain a personnel record for each staff person at the program that must contain:

(1) the staff person's name, home address, telephone number, and date of birth;

(2) documentation that the staff person completed training required by section 245G.14;

(3) documentation of the date the program initiated a background study for the staff person; and

(4) documentation of the date the staff person first had direct contact and access to a child while supervised, and the date the staff person first had direct contact and access to a child while unsupervised.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 51. **[245G.17] CERTIFICATION STANDARDS.**

The commissioner shall regularly consult with stakeholders for input related to implementing the standards in this chapter.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 52. **[245G.18] PARENTAL ACCESS.**

An enrolled child's parent or legal guardian must be allowed access to the parent's or legal guardian's child at any time while the child is in care.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 53. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

(b) "Commissioner" means the commissioner of human services.

(c) "Facility" means:

(1) a licensed or unlicensed day care facility, certified license-exempt child care center, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245D or 245G;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

(3) a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

(d) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege sexual abuse or substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(e) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve sexual abuse or substantial child endangerment, and for reports of maltreatment in facilities required to be licensed or certified under chapter 245A ~~or~~, 245D, or 245G; under sections 144.50 to 144.58 and 241.021; in a school as defined in section 120A.05,

subdivisions 9, 11, and 13, and chapter 124E; or in a nonlicensed personal care provider association as defined in section 256B.0625, subdivision 19a.

(f) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

(g) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in

the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(h) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

(i) "Operator" means an operator or agency as defined in section 245A.02.

(j) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian,

or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(k) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;

(9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(11) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Report" means any communication received by the local welfare agency, police department, county sheriff, or agency responsible for child protection pursuant to this section that describes neglect or physical or sexual abuse of a child and contains sufficient content to identify the child and any person believed to be responsible for the neglect or abuse, if known.

(n) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports of known or suspected child sex trafficking involving a child who is identified as a victim of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321, subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(o) "Substantial child endangerment" means a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) solicitation, inducement, and promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) solicitation of children to engage in sexual conduct under section 609.352;

(10) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(11) use of a minor in sexual performance under section 617.246; or

(12) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

(p) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (j), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (q) from the Department of Human Services.

(q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (p), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(r) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

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

Sec. 54. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing or certifying the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245D or 245G; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Notification requirements under subdivision 10 apply to all reports received under this section.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

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

Sec. 55. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The ~~county~~ local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally ~~unlicensed~~ nonlicensed child care, ~~juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county,~~ and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal

care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A ~~and~~, 245D, and 245G, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482.

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

Sec. 56. Minnesota Statutes 2016, section 626.556, subdivision 4, is amended to read:

Subd. 4. **Immunity from liability.** (a) The following persons are immune from any civil or criminal liability that otherwise might result from their actions, if they are acting in good faith:

(1) any person making a voluntary or mandated report under subdivision 3 or under section 626.5561 or assisting in an assessment under this section or under section 626.5561;

(2) any person with responsibility for performing duties under this section or supervisor employed by a local welfare agency, the commissioner of an agency responsible for operating or supervising a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed or certified under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B~~,~~ or 245G; or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a, complying with subdivision 10d; and

(3) any public or private school, facility as defined in subdivision 2, or the employee of any public or private school or facility who permits access by a local welfare agency, the Department of Education, or a local law enforcement agency and assists in an investigation or assessment pursuant to subdivision 10 or under section 626.5561.

(b) A person who is a supervisor or person with responsibility for performing duties under this section employed by a local welfare agency, the commissioner of human services, or the commissioner of education complying with subdivisions 10 and 11 or section 626.5561 or any related rule or provision of law is immune from any civil or criminal liability that

might otherwise result from the person's actions, if the person is (1) acting in good faith and exercising due care, or (2) acting in good faith and following the information collection procedures established under subdivision 10, paragraphs (h), (i), and (j).

(c) This subdivision does not provide immunity to any person for failure to make a required report or for committing neglect, physical abuse, or sexual abuse of a child.

(d) If a person who makes a voluntary or mandatory report under subdivision 3 prevails in a civil action from which the person has been granted immunity under this subdivision, the court may award the person attorney fees and costs.

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

Sec. 57. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed or certified according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 245D or 245G, or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an assessment or investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical

abuse, sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian previously notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation. In the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification to parents, guardians, or legal custodians of each child in the facility, but shall, within ten days after the investigation is completed, provide written notification to the parent, guardian, or legal custodian of any student alleged to have been maltreated. The commissioner of education may notify the parent, guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

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

Sec. 58. Minnesota Statutes 2016, section 626.556, subdivision 10e, is amended to read:

Subd. 10e. **Determinations.** (a) The local welfare agency shall conclude the family assessment or the investigation within 45 days of the receipt of a report. The conclusion of the assessment or investigation may be extended to permit the completion of a criminal investigation or the receipt of expert information requested within 45 days of the receipt of the report.

(b) After conducting a family assessment, the local welfare agency shall determine whether services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment.

(c) After conducting an investigation, the local welfare agency shall make two determinations: first, whether maltreatment has occurred; and second, whether child protective services are needed. No determination of maltreatment shall be made when the alleged perpetrator is a child under the age of ten.

(d) If the commissioner of education conducts an assessment or investigation, the commissioner shall determine whether maltreatment occurred and what corrective or protective action was taken by the school facility. If a determination is made that maltreatment has occurred, the commissioner shall report to the employer, the school board, and any appropriate licensing entity the determination that maltreatment occurred and what corrective or protective action was taken by the school facility. In all other cases, the commissioner shall inform the school board or employer that a report was received, the subject of the report, the date of the initial report, the category of maltreatment alleged as defined in paragraph (f), the fact that maltreatment was not determined, and a summary of the specific reasons for the determination.

(e) When maltreatment is determined in an investigation involving a facility, the investigating agency shall also determine whether the facility or individual was responsible, or whether both the facility and the individual were responsible for the maltreatment using the mitigating factors in paragraph (i). Determinations under this subdivision must be made based on a preponderance of the evidence and are private data on individuals or nonpublic data as maintained by the commissioner of education.

(f) For the purposes of this subdivision, "maltreatment" means any of the following acts or omissions:

(1) physical abuse as defined in subdivision 2, paragraph (k);

(2) neglect as defined in subdivision 2, paragraph (g);

(3) sexual abuse as defined in subdivision 2, paragraph (n);

(4) mental injury as defined in subdivision 2, paragraph (f); or

(5) maltreatment of a child in a facility as defined in subdivision 2, paragraph (c).

(g) For the purposes of this subdivision, a determination that child protective services are needed means that the local welfare agency has documented conditions during the assessment or investigation sufficient to cause a child protection worker, as defined in section 626.559, subdivision 1, to conclude that a child is at significant risk of maltreatment if protective intervention is not provided and that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment.

(h) This subdivision does not mean that maltreatment has occurred solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child, in lieu of medical care. However, if lack of medical care may result in serious danger to the child's health, the local welfare agency may ensure that necessary medical services are provided to the child.

(i) When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

The evaluation of the facility's responsibility under clause (2) must not be based on the completeness of the risk assessment or risk reduction plan required under section 245A.66, but must be based on the facility's compliance with the regulatory standards for policies and procedures, training, and supervision as cited in Minnesota Statutes and Minnesota Rules.

(j) Notwithstanding paragraph (i), when maltreatment is determined to have been committed by an individual who is also the facility license or certification holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing or certification actions under ~~sections~~ section 245A.06 ~~or~~, 245A.07, 245G.06, or 245G.07 apply.

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

Sec. 59. Minnesota Statutes 2016, section 626.556, subdivision 10f, is amended to read:

Subd. 10f. **Notice of determinations.** Within ten working days of the conclusion of a family assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent child maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed. Within ten working days of the conclusion of an investigation, the local welfare agency or agency responsible for investigating the report shall notify the parent or guardian of the child, the person determined to be maltreating the child, and, if applicable, the director of the facility, of the determination and a summary of the specific reasons for the determination. When the investigation involves a child foster care setting that is monitored by a private licensing agency under section 245A.16, the local welfare agency responsible for investigating the report shall notify the private licensing agency of the determination and shall provide a summary of the specific reasons for the determination. The notice to the private licensing agency must include identifying private data, but not the identity of the reporter of maltreatment. The notice must also include a certification that the information collection procedures under subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a data subject to obtain access to other private data on the subject collected, created, or maintained under this section. In addition, the notice shall include the length of time that the records will be kept under subdivision 11c. The investigating agency shall notify the parent or guardian of the child who is the subject of the report, and any person or facility determined to have maltreated a child, of their appeal or review rights under this section. The notice must also state that a

finding of maltreatment may result in denial of a license or certification application or background study disqualification under chapter 245C related to employment or services that are licensed or certified by the Department of Human Services under chapter 245A or 245G, the Department of Health under chapter 144 or 144A, the Department of Corrections under section 241.021, and from providing services related to an unlicensed personal care provider organization under chapter 256B.

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

Sec. 60. Minnesota Statutes 2016, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative reconsideration is not applicable in family assessments since no determination concerning maltreatment is made. For investigations, except as provided under paragraph (e), an individual or facility that the commissioner of human services, a local social service agency, or the commissioner of education determines has maltreated a child, an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the request for reconsideration must be postmarked and sent to the investigating agency within 15 calendar days of the individual's or facility's receipt of the final determination. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 15 calendar days after the individual's or facility's receipt of the final determination. Effective January 1, 2002, an individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the investigating agency within 30 calendar days of the individual's receipt of the maltreatment determination and notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services or the commissioner of education a written request for a hearing under that section. Section 256.045 also governs hearings requested to contest a final determination of the commissioner of education. The investigating agency shall notify persons who request reconsideration of their rights under this paragraph. The hearings specified under this section are the only administrative appeal of a decision issued under paragraph (a). Determinations under this section are not subject to accuracy and completeness challenges under section 13.04.

(c) If, as a result of a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied and the individual remains disqualified following a reconsideration decision, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license.

In such cases, a fair hearing regarding the maltreatment determination and disqualification shall not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination as provided under this subdivision, and reconsideration of a disqualification as provided under section 245C.22, shall also not be conducted when:

(1) a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment.

(h) If a maltreatment determination is the basis for a correction order under section 245G.06 or decertification under section 245G.07, the certification holder has the right to request reconsideration under sections 245G.06 and 245G.07. If the certification holder appeals the maltreatment determination or disqualification, but does not appeal the correction order or decertification, reconsideration of the maltreatment determination shall be conducted under section 626.556, subdivision 10i, and reconsideration of the disqualification shall be conducted under section 245C.22.

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

ARTICLE 17

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2015, chapter 71, article 14, as amended by Laws 2016, chapter 189, articles 22 and 23, from the general fund, or any other fund named, to the Department of Human Services for the purposes specified in this article, to be available for the fiscal years indicated for each purpose. The figure "2017" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2017.

	APPROPRIATIONS Available for the Year Ending June 30 2017
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (342,045,000)**
Appropriations by Fund	
2017	
General Fund (198,450,000)	
Health Care Access (146,590,000)	
TANF 2,995,000	
Subd. 2. **Forecasted Programs**	
(a) **MFIP/DWP Grants**	
Appropriations by Fund	
General Fund (2,111,000)	
TANF 2,579,000	
(b) **MFIP Child Care Assistance Grants**	(6,513,000)
(c) **General Assistance Grants**	(4,219,000)
(d) **Minnesota Supplemental Aid Grants**	(581,000)
(e) **Group Residential Housing Grants**	(533,000)
(f) **Northstar Care for Children**	2,613,000

(g) **MinnesotaCare Grants** (145,883,000)

This appropriation is from the health care access fund.

(h) **Medical Assistance Grants**

Appropriations by Fund	
General Fund	(192,744,000)
Health Care Access	(707,000)

(i) **Alternative Care Grants** -0-

(j) **CD Entitlement Grants** 5,638,000

Subd. 3. **Technical Activities** 416,000

This appropriation is from the TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 18

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 "2018" and "2019" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2018	**2019**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 7,550,197,000 $ 7,656,412,000**

Appropriations by Fund

	2018	2019
General	6,819,523,000	6,880,153,000
State Government Special Revenue	4,274,000	4,274,000
Health Care Access	446,453,000	501,104,000
Federal TANF	278,051,000	268,985,000
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) 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 working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) For the activities listed in paragraph (a), clauses (2) to (8), 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) 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) The commissioner may 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) For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) 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 2017, 2018, and 2019 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	136,778,000	121,009,000
State Government Special Revenue	4,149,000	4,149,000
Health Care Access	21,019,000	21,019,000
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) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Transfer to Office of Legislative Auditor.** $600,000 in fiscal year 2018 and $600,000 in fiscal year 2019 are for transfer to the Office of the Legislative Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2b.

(c) **Base Level Adjustment.** The general fund base is $133,378,000 in fiscal year 2020 and $133,418,000 in fiscal year 2021.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	10,438,000	10,431,000
Federal TANF	2,582,000	2,582,000

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2018 and fiscal year 2019 from the systems special revenue account 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.

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	20,719,000	21,249,000
Health Care Access	23,697,000	23,804,000

(a) **Integrated Health Partnership Health Information Exchange.** $125,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are from the general fund to contract with state-certified health information exchange vendors to support providers participating in an integrated health partnership under Minnesota Statutes, section 256B.0755, to connect enrollees with community supports and social services and improve collaboration among participating and authorized providers.

(b) **Transfer to Legislative Auditor.** 153,000 in fiscal year 2018 and $153,000 in fiscal year 2019 are from the general fund for transfer to the Office of the Legislative Auditor for the auditor to establish and maintain a team of auditors with the training and experience necessary to fulfill the requirements in Minnesota Statutes, section 3.972, subdivision 2a.

(c) **Base Level Adjustment.** The general fund base is $21,257,000 in fiscal year 2020 and $21,302,000 in fiscal year 2021.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	15,359,000	15,113,000
State Government Special Revenue	125,000	125,000

(a) **Alzheimer's Disease Working Group.** $127,000 in fiscal year 2018 and $110,000 in fiscal year 2019 are from the general fund for the Alzheimer's disease working group. This is a onetime appropriation.

(b) **Base Level Adjustment.** The general fund base is $15,053,000 in fiscal year 2020 and $15,053,000 in fiscal year 2021.

Subd. 7. **Central Office; Community Supports**

	Appropriations by Fund	
General	29,546,000	29,381,000
Lottery Prize	163,000	163,000

(a) **Transportation Study.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for a study to identify opportunities to increase access to transportation services for individuals who receive home and

community-based services. This is a onetime appropriation.

(b) **Deaf and Hard-of-Hearing Services.** $438,000 in fiscal year 2018 and $395,000 in fiscal year 2019 are from the general fund for the Deaf and Hard-of-Hearing Services Division under Minnesota Statutes, section 256C.233.

(c) **Consumer-Directed Community Supports Revised Budget Methodology Report.** $435,000 in fiscal year 2018 and $65,000 in fiscal year 2019 are from the general fund to study and develop an individual budgeting model for disability waiver recipients and those accessing services through consumer-directed community supports. The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over these programs by December 15, 2018. This is a onetime appropriation.

(d) **Substance Use Disorder System Study.** $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for a substance use disorder system study. This is a onetime appropriation.

(e) **Children's Mental Health Report and Recommendations.** $125,000 in fiscal year 2018 and $125,000 in fiscal year 2019 are for a comprehensive analysis of Minnesota's continuum of intensive mental health services for children with serious mental health needs. This is a onetime appropriation.

(f) **Self-Directed Workforce Collective Bargaining Agreement.** $1,206,000 in fiscal year 2018 and $1,206,000 in fiscal year 2019 may be used for administration, training, grants, and reimbursement to implement a collective bargaining agreement between the state and the Service Employees International Union Healthcare Minnesota (SEIU). This appropriation is not available until the collective bargaining agreement between the state and SEIU under Minnesota Statutes, section 179A.54, is approved under subdivision 15, paragraph (b), clause (3). The commissioner may transfer funds between budget activities with the approval of the commissioner of management and budget.

(g) **Implementation and Operation of an Electronic Service Delivery Documentation System.** $170,000 in fiscal year 2018 and $105,000 in fiscal year 2019 are from the general fund for the development and implementation of an electronic service delivery documentation system. This is a onetime appropriation.

(h) **Base Level Adjustment.** The general fund base is $27,504,000 in fiscal year 2020 and $27,328,000 in fiscal year 2021.

Subd. 8. **Forecasted Programs; MFIP/DWP**

Appropriations by Fund		
General	88,930,000	98,251,000
Federal TANF	92,732,000	83,513,000

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance**	101,293,000	112,078,000
Subd. 10. **Forecasted Programs; General Assistance**	55,536,000	57,221,000

(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 2018 and $6,729,812 in fiscal year 2019. 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**	40,484,000	41,634,000
Subd. 12. **Forecasted Programs; Group Residential Housing**	169,312,000	179,643,000

Eliminate Group Residential Housing Grant. The forecasted base funding for the group residential housing program shall be reduced by $460,000 in fiscal year 2018 and $460,000 in fiscal year 2019 to reflect the elimination of grant funding for facilities under Minnesota Statutes, section 256I.05, subdivision 1m. The ongoing base funding shall be adjusted to reflect the elimination of this grant.

Subd. 13. **Forecasted Programs; Northstar Care for Children**	80,542,000	96,433,000
Subd. 14. **Forecasted Programs; MinnesotaCare**	12,363,000	13,218,000

This appropriation is from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

	Appropriations by Fund	
General	5,174,539,000	5,172,692,000
Health Care Access	385,159,000	438,848,000

(a) **Behavioral Health Services.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 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) **Self-Directed Workforce Collective Bargaining Agreement.** (1) This appropriation includes money to implement a collective bargaining agreement between the state and the Service Employees International Union Healthcare Minnesota (SEIU). This appropriation is not available until the collective bargaining agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved as provided in clause (3).

(2) The commissioner of management and budget is authorized to negotiate and enter into a collective bargaining agreement with SEIU under Minnesota Statutes, section 179A.54, subject to the amount appropriated in clause (1). The economic terms of the

collective bargaining agreement may include wage floor increases for direct support workers, paid time off, holiday pay, wage increases for workers serving people with complex needs, training stipends, and training for direct support workers and for implementation of the registry as outlined in the collective bargaining agreement.

(3) Notwithstanding Minnesota Statutes, sections 3.855, 179A.22, subdivision 4, and 179A.54, subdivision 5, upon approval of a negotiated collective bargaining agreement by the SEIU and the commissioner of management and budget, the commissioner of human services is authorized to implement the negotiated collective bargaining agreement.

Subd. 16. **Forecasted Programs; Alternative Care** 44,258,000 44,976,000

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** 117,226,000 136,493,000

Subd. 18. **Grant Programs; Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	96,311,000	96,311,000

Subd. 19. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 44,690,000 53,413,000

(a) **Maximum Rate for Certain Child Care Providers.** Notwithstanding Minnesota Statutes, section 119B.03, subdivisions 6 and

6a, $25,000 in fiscal year 2019 is to modify maximum rates for child care providers in a city with boundaries located in two or more of the counties of Benton, Sherburne, and Stearns. $12,000 of the funding for the calendar year 2018 allocation and $29,000 of the funding for the calendar year 2019 allocation shall be allocated proportionally to the three counties based on county expenditures in the most recent calendar year. Allocations in calendar year 2020 and beyond shall be calculated using the allocation formula in Minnesota Statutes, section 119B.03, subdivision 6.

(b) Base Level Adjustment. The general fund base is $53,583,000 in fiscal year 2020 and $53,639,000 in fiscal year 2021.

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	39,240,000	39,165,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** (1) 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.

(2) 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) **Adoption Assistance Incentive Grants.** (1) The commissioner shall allocate federal funds available for adoption and guardianship assistance incentive grants for postadoption services to support adoptive, foster, and kinship families as required in Minnesota Statutes, section 256N.261.

(2) Federal funds available during fiscal year 2019 for adoption incentive grants must be used for foster care, adoption, and kinship services, including a parent-to-parent support network.

(c) **Adoption Support Services.** The commissioner shall allocate 20 percent of federal funds from title IV-B, subpart 2, of the Social Security Act, Promoting Safe and Stable Families, for adoption support services under Minnesota Statutes, section 256N.261.

(d) **Anoka County Family Foster Care.** $75,000 in fiscal year 2018 is from the general fund for a grant to Anoka County to establish and promote family foster care recruitment models. The county shall use the grant funds for the purpose of increasing foster care providers through administrative simplification, nontraditional recruitment models, and family incentive options, and develop a strategic planning model to recruit family foster care providers. This is a onetime appropriation.

(e) **White Earth Band of Ojibwe Child Welfare Services.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are from the general fund for a grant to the White Earth Band of Ojibwe to deliver child welfare services.

Subd. 23. **Grant Programs; Children and Community Service Grants**	58,201,000	58,201,000
Subd. 24. **Grant Programs; Children and Economic Support Grants**	32,930,000	32,940,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2018 do not cancel but are available for this purpose in fiscal year 2019.

(b) **Long-term Homeless Supportive Services.** $375,000 in fiscal year 2018 and $375,000 in fiscal year 2019 are for the long-term homeless supportive services fund under Minnesota Statutes, section 256K.26. This is a onetime appropriation.

(c) **Community Action Grants.** $750,000 in fiscal year 2018 and $750,000 in fiscal year 2019 are for community action grants under Minnesota Statutes, sections 256E.30 to 256E.32. This is a onetime appropriation.

(d) **Transitional Housing.** $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are for the transitional housing program under Minnesota Statutes, section 256E.33. This is a onetime appropriation.

(e) **Family Assets for Independence.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for the family assets for independence program under Minnesota

Statutes, section 256E.35. This is a onetime appropriation.

(f) **Safe Harbor for Sexually Exploited Youth.** (1) $400,000 in fiscal year 2018 and $400,000 in fiscal year 2019 are for emergency shelter and transitional and long-term housing beds for sexually exploited youth and youth at risk of sexual exploitation.

(2) $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are for statewide youth outreach workers connecting sexually exploited youth and youth at risk of sexual exploitation with shelter and services.

(3) Youth 24 years of age or younger are eligible for shelter, housing beds, and services under this paragraph. In funding shelter, housing beds, and outreach workers under this paragraph, the commissioner shall emphasize activities that promote capacity-building and development of resources in greater Minnesota.

(g) **Emergency Services Program.** $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are for the emergency services program, which provides services and emergency shelter for homeless Minnesotans under Minnesota Statutes, section 256E.36. This is a onetime appropriation.

(h) **Dakota County Child Data Tracking.** $200,000 in fiscal year 2018 is for the Minnesota Birth to Eight pilot project for the development of the information technology solution that will track the established

developmental milestone progress of each child participating in the pilot up to age eight.

(i) **Food Shelf Programs.** $375,000 in fiscal year 2018 and $375,000 in fiscal year 2019 are for food shelf programs under Minnesota Statutes, section 256E.34. This appropriation may be used to purchase proteins, fruits, vegetables, and diapers. This is a onetime appropriation.

(j) **Community Living Infrastructure.** $1,400,000 in fiscal year 2018 and $1,400,000 in fiscal year 2019 are for community living infrastructure grant allocations under article 2, section 17.

(k) **Housing Web Site Grant.** $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for a grant to a public or private entity to create and maintain a Web site and application to track real-time housing openings for people with disabilities.

(l) **Housing Benefit Web Site.** $130,000 in fiscal year 2018 and $130,000 in fiscal year 2019 are to operate the housing benefit 101 Web site to help people who need affordable housing, and supports to maintain that housing, understand the range of housing options and support services available.

(m) **Coparenting Education.** $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for a grant to a health and wellness center located in North Minneapolis that is a federally qualified health center. This is a onetime appropriation. The center must use the grant money to offer coparent services to

unmarried parents. The center must develop a process to inform and educate unmarried parents about the center's coparent services. The coparent services must include the following:

(1) coparenting workshops for the unmarried parents;

(2) assistance to the unmarried parents in developing a parenting plan that specifies a schedule of the time each parent spends with the child, child support obligations, and a designation of decision-making responsibilities regarding the child's education, medical needs, and religious upbringing;

(3) an assessment of social services needs for each parent; and

(4) additional social services support, including support related to employment, education, and housing.

The parenting plan assistance must include the option of using private mediation.

The coparent workshops must focus at a minimum on (i) the benefits to the child of having both parents involved in a child's life, (ii) promoting both parents' participation in a child's life, (iii) building coparenting and communication skills, (iv) information on establishing paternity, (v) assisting parents in developing a parenting plan, and (vi) educating participants on how to foster a nonresident parent's continued involvement in a child's life.

(n) **Base Level Adjustments.** The general fund base is $30,840,000 in fiscal year 2020

and $31,940,000 in fiscal year 2021. The general fund base includes $453,000 in fiscal year 2020 and $453,000 in fiscal year 2021 for community living infrastructure grant allocations under Minnesota Statutes, section 256I.09.

Subd. 25. **Grant Programs; Health Care Grants**

	Appropriations by Fund	
General	5,119,000	3,711,000
Health Care Access	3,465,000	3,465,000

Chronic Pain Rehabilitation Therapy Demonstration Project. $1,000,000 in fiscal year 2018 is from the general fund for a chronic pain rehabilitation therapy demonstration project with a rehabilitation institute. The commissioner may use up to three percent of this appropriation for administrative costs for the project. This is a onetime appropriation.

Subd. 26. **Grant Programs; Other Long-Term Care Grants** 2,500,000 2,925,000

(a) **Home and Community-Based Incentive Pool.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are for incentive payments under Minnesota Statutes, section 256B.0921. This is a onetime appropriation.

(b) **Base Level Adjustment.** The general fund base is $1,925,000 in fiscal year 2020 and $1,925,000 in fiscal year 2021.

Subd. 27. **Grant Programs; Aging and Adult Services Grants** 30,786,000 32,437,000

(a) **Gap Analysis.** $217,000 in fiscal year 2018 and $218,000 in fiscal year 2019 are for

analysis of gaps in long-term care services under Minnesota Statutes, section 144A.351.

(b) **Advanced In-Home Activity-Monitoring Systems.** $40,000 in fiscal year 2018 is for a grant to a local research organization with expertise in identifying current and potential support systems and examining the capacity of those systems to meet the needs of the growing population of elderly persons to conduct a comprehensive assessment of current literature, past research, and an environmental scan of the field related to advanced in-home activity-monitoring systems for elderly persons. The commissioner must report the results of the assessment by January 15, 2018, to the legislative committees and divisions with jurisdiction over health and human services policy and finance. This is a onetime appropriation.

(c) **Base Level Adjustments.** The general fund base is $32,811,000 in fiscal year 2020 and $32,995,000 in fiscal year 2021. The general fund base includes $334,000 in fiscal year 2020 and $477,000 in fiscal year 2021 for the Minnesota Board on Aging for self-directed caregiver grants under Minnesota Statutes, section 256.975, subdivision 12.

Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants**	2,675,000	2,675,000

Expanded Services Grants. $800,000 in fiscal year 2018 and $800,000 in fiscal year 2019 are for deaf and hard-of-hearing grants. The funds must be used to:

(1) provide linguistically and culturally appropriate mental health services for children

who are deaf, children who are deafblind, and children who are hard-of-hearing in northwestern and northeastern Minnesota;

(2) provide psychiatric services statewide for people who are deaf, people who are deafblind, and people who are hard-of-hearing; and

(3) provide services and assistive technology for people who are deafblind throughout Minnesota.

Subd. 29. **Grant Programs; Disabilities Grants**	21,175,000	21,176,000

(a) **Disability Waiver Rate System Transition Grants.** $30,000 in fiscal year 2018 and $31,000 in fiscal year 2019 are for grants to home and community-based disability waiver services providers that are projected to receive at least a ten percent decrease in revenues due to transition to rates calculated under Minnesota Statutes, section 256B.4914.The commissioner shall award grants to ensure ongoing access for individuals currently receiving these services and provide stability to providers as they transition to new service delivery models. The general fund base for the grants under this paragraph is $287,000 in fiscal year 2020 and $288,000 in fiscal year 2021.

(b) **Self-Advocacy Grants.** $133,000 in fiscal year 2018 and $133,000 in fiscal year 2019 are for grants under Minnesota Statutes, section 256.477, paragraph (a).

(c) **Services for Persons with Intellectual and Developmental Disabilities.** $143,000 in fiscal year 2018 and $143,000 in fiscal year

2019 are for a grant to an organization described under Minnesota Statutes, section 256.477. This is a onetime appropriation. Grant funds must be used for the following purposes:

(1) to maintain the infrastructure needed to train and support the activities of a statewide network of peer-to-peer mentors for persons with developmental disabilities, focused on building awareness of service options and advocacy skills necessary to move toward full inclusion in community life, including the development and delivery of the curriculum to support the peer-to-peer network;

(2) to provide outreach activities, including statewide conferences and disability networking opportunities focused on self-advocacy, informed choice, and community engagement skills;

(3) to provide an annual leadership program for persons with intellectual and developmental disabilities; and

(4) to provide for administrative and general operating costs associated with managing and maintaining facilities, program delivery, evaluation, staff, and technology.

(d) **Outreach to Persons in Institutional Settings.** $105,000 in fiscal year 2018 and $105,000 in fiscal year 2019 are for a grant to an organization described under Minnesota Statutes, section 256.477, to be used for subgrants to organizations in Minnesota to conduct outreach to persons working and living in institutional settings to provide

education and information about community options. This is a onetime appropriation. Grant funds must be used to deliver peer-led skill training sessions in six regions of the state to help persons with intellectual and developmental disabilities understand community service options related to:

(1) housing;

(2) employment;

(3) education;

(4) transportation;

(5) emerging service reform initiatives contained in the state's Olmstead plan; the Workforce Innovation and Opportunity Act, Public Law 113-128; and federal home and community-based services regulations; and

(6) connecting with individuals who can help persons with intellectual and developmental disabilities make an informed choice and plan for a transition in services.

(e) **Community Living Grants.** To the extent funding is available, the commissioner may transfer funds from the semi-independent living services grant to new community living grants to pay for transitional costs and facilitate the transition of individuals from corporate foster care to community living.

(f) **Life Skills Training for Individuals with Autism Spectrum Disorder.** $125,000 in fiscal year 2018 and $125,000 in fiscal year 2019 are for a grant to an organization located in Richfield that provides life skills training to young adults with learning disabilities to

meet the needs of individuals with autism spectrum disorder. This is a onetime appropriation. This appropriation may be used to:

(1) create a best practices curriculum for serving individuals with autism spectrum disorder in residential placements with therapeutic programming; and

(2) expand facilities by adding safety features, living spaces, and academic areas.

(g) **Base Level Adjustment.** The general fund base is $21,059,000 in fiscal year 2020 and $21,060,000 in fiscal year 2021.

Subd. 30. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	81,577,000	81,477,000
Health Care Access	750,000	750,000

(a) **Peer-Run Respite Services in Wadena County.** $100,000 in fiscal year 2018 is from the general fund for a grant to Wadena County for the planning and development of a peer-run respite center for individuals experiencing mental health conditions or co-occurring substance abuse disorder. This is a onetime appropriation and is available until June 30, 2021. The grant is contingent on Wadena County providing to the commissioner of human services a plan to fund, operate, and sustain the program and services after the onetime state grant is expended. Wadena County must outline the proposed funding stream or mechanism, and any necessary local funding commitment, which will ensure the program will result in a sustainable program.

The funding stream may include state funding for programs and services for which the individuals served under this paragraph may be eligible. The commissioner of human services, in collaboration with Wadena County, may explore a plan for continued funding using existing appropriations through eligibility for group residential housing under Minnesota Statutes, chapter 256I.

The peer-run respite center must:

(1) admit individuals who are in need of peer support and supportive services while addressing an increase in symptoms or stressors or exacerbation of their mental health or substance abuse;

(2) admit individuals to reside at the center on a short-term basis, no longer than five days;

(3) be operated by a nonprofit organization;

(4) employ individuals who have personal experience with mental health or co-occurring substance abuse conditions who meet the qualifications of a mental health certified peer specialist under Minnesota Statutes, section 256B.0615, or a recovery peer;

(5) provide at least three but no more than six beds in private rooms; and

(6) not provide clinical services.

By November 1, 2018, the commissioner of human services, in consultation with Wadena County, shall report to the committees in the senate and house of representatives with jurisdiction over mental health issues, the status of planning and development of the

peer-run respite center, and the plan to financially support the program and services after the state grant is expended.

(b) **Housing Options for Persons with Serious Mental Illness.** $575,000 in fiscal year 2018 and $575,000 in fiscal year 2019 are from the general fund for adult mental health grants under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (a), clause (2), to support increased availability of housing options with supports for persons with serious mental illness. This is a onetime appropriation.

(c) **Assertive Community Treatment.** $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are from the general fund for adult mental health grants under Minnesota Statutes, section 256B.0622, subdivision 12, to expand assertive community treatment services. This is a onetime appropriation.

(d) **Mental Health Crisis Services.** $400,000 in fiscal year 2018 and $400,000 in fiscal year 2019 are from the general fund for adult mental health grants under Minnesota Statutes, section 245.4661, and children's mental health grants under Minnesota Statutes, section 245.4889, to expand mental health crisis services, including:

(1) mobile crisis services;

(2) residential crisis services;

(3) colocation of mobile crisis services in urgent care clinics and psychiatric emergency departments; and

(4) development of co-responder mental health crisis response models.

This is a onetime appropriation.

(e) **Housing with Supports.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are for the housing with supports for adults with serious mental illness grant under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (a), clause (2). This is a onetime appropriation.

(f) **Base Level Adjustment.** The general fund base is $79,802,000 in fiscal year 2020 and $79,802,000 in fiscal year 2021.

Subd. 31. **Grant Programs; Child Mental Health Grants** 21,411,000 21,476,000

(a) **First Psychotic Episode Funding.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are for grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15). This is a onetime appropriation. Funding shall be used to:

(1) provide intensive treatment and supports to adolescents and adults experiencing or at risk of a first psychotic episode. Intensive treatment and support includes medication management, psychoeducation for the individual and family, case management, employment supports, education supports, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management. Projects must use all available funding streams;

(2) conduct outreach, training, and guidance to mental health and health care professionals, including postsecondary health clinics, on early psychosis symptoms, screening tools, and best practices; and

(3) ensure access to first psychotic episode psychosis services under this section, including ensuring access for individuals who live in rural areas. Funds may be used to pay for housing or travel or to address other barriers to individuals and their families participating in first psychotic episode services.

(b) **Respite Care Services.** $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for children's mental health grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (3), to provide respite care services to families of children with serious mental illness. This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is $20,826,000 in fiscal year 2020 and $20,826,000 in fiscal year 2021.

Subd. 32. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	2,386,000	2,386,000
Lottery Prize	1,733,000	1,733,000

(a) **Minnesota Transitions Charter School.** Notwithstanding any other law to the contrary, Minnesota Transitions Charter School is eligible to receive grants under Minnesota Statutes, section 254A.03, subdivision 1.

(b) **Problem Gambling.** $225,000 in fiscal year 2018 and $225,000 in fiscal year 2019 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.

(c) **Minnesota Organization on Fetal Alcohol Syndrome.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for a grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). This is a onetime appropriation. Of this amount, MOFAS shall make grants to eligible regional collaboratives that fulfill the requirements in this paragraph. "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 paragraph, a local government includes a county or multicounty organization, a tribal government, a county-based purchasing entity, or a community health board. Eligible regional collaboratives must use grant funds to reduce the incidence of fetal alcohol syndrome 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. The eligible regional collaboratives must provide intensive services

to chemically dependent women to increase positive birth outcomes. MOFAS must make grants to eligible regional collaboratives from both rural and urban areas. A grant recipient must report to the commissioner of human services annually by January 15 on the services and programs funded by the appropriation. 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.

(d) **Base Level Adjustment.** The general fund base is $2,136,000 in fiscal year 2020 and $2,136,000 in fiscal year 2021.

Subd. 33. **Direct Care and Treatment - Generally**

(a) **Transfer Authority.** Money appropriated to budget activities under subdivisions 34, 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) **Dedicated Receipts Available.** Of the revenue received under Minnesota Statutes, section 246.18, subdivision 8, paragraph (a), up to $1,000,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (1); and up to $2,713,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (2).

Subd. 34. **Direct Care and Treatment - Mental Health and Substance Abuse** 118,545,000 118,631,000

(a) **Child and Adolescent Behavioral Health Services.** $405,000 in fiscal year 2018 and $491,000 in fiscal year 2019 are to continue to operate the child and adolescent behavioral health services program under Minnesota Statutes, section 246.014. This is a onetime appropriation.

(b) **DCT Operating Adjustment (CARE).** $447,000 in fiscal year 2018 and $447,000 in fiscal year 2019 are for Community Addiction Recovery Enterprise (CARE) operating adjustments. The commissioner must transfer $447,000 in fiscal year 2018 and $447,000 in fiscal year 2019 to the enterprise fund for CARE.

(c) **Base Level Adjustment.** The general fund base is $118,140,000 in fiscal year 2020 and $118,140,000 in fiscal year 2021.

Subd. 35. **Direct Care and Treatment - Community-Based Services** 25,652,000 20,543,000

(a) **DCT Operating Adjustment (MSOCS).** $2,393,000 in fiscal year 2018 and $2,393,000 in fiscal year 2019 are for Minnesota State Operated Community Services (MSOCS) operating adjustments. The commissioner must transfer $2,393,000 in fiscal year 2018 and $2,393,000 in fiscal year 2019 to the enterprise fund for MSOCS.

(b) **MSOCS Sustainability.** $7,697,000 in fiscal year 2018 and $2,588,000 in fiscal year 2019 are for the Minnesota State Operated Community Services program. Of this amount, the commissioner must transfer $6,697,000 in fiscal year 2018 and $1,588,000 in fiscal year 2019 to the enterprise fund for Minnesota State

Operated Community Services. $1,000,000 is available each year of the biennium for start-up expenses for new residential homes to be operated by Minnesota State Operated Community Services.

(c) **Base Level Adjustment.** The general fund base is $18,955,000 in fiscal year 2021.

Subd. 36. **Direct Care and Treatment - Forensic Services** 102,806,000 106,958,000

Base Level Adjustment. The general fund base in fiscal year 2020 is $109,828,000 and $112,437,000 in fiscal year 2021.

Subd. 37. **Direct Care and Treatment - Sex Offender Program** 89,217,000 89,225,000

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.

Subd. 38. **Direct Care and Treatment - Operations** 45,151,000 45,708,000

Base Level Adjustment. The general fund base is $45,995,000 in fiscal year 2020 and $46,256,000 in fiscal year 2021.

Subd. 39. **Technical Activities** 86,186,000 86,339,000

(a) This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund base is $86,346,000 in fiscal year 2020 and $86,355,000 in fiscal year 2021.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 213,792,000 $ 207,347,000**

Appropriations by Fund

	2018	2019
General	111,829,000	105,274,000
State Government Special Revenue	53,607,000	54,102,000
Health Care Access	36,643,000	36,258,000
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	81,438,000	78,100,000
State Government Special Revenue	6,215,000	6,182,000
Health Care Access	36,643,000	36,258,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 of the TANF fund each year is for home visiting and nutritional services listed 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 of the TANF fund each year is for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(3) $4,978,000 of the TANF fund each year is for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal

governments according to Minnesota Statutes, section 145A.14, subdivision 2a.

(4) $1,156,000 of the TANF fund each year is for family planning grants under Minnesota Statutes, section 145.925.

(5) The commissioner may use up to 6.23 percent of the funds appropriated 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) **Evidence-Based Home Visiting.** $6,000,000 in fiscal year 2018 and $6,000,000 in fiscal year 2019 are from the general fund to start up or expand evidence-based home visiting programs. The commissioner shall award grants to community health boards, nonprofits, or tribal nations in urban and rural areas of the state. Grant funds must be used to start up or expand evidence-based home visiting programs in the county, reservation, or region to serve families, such as parents with high risk or high needs, parents with a history of mental illness, domestic abuse, or substance abuse, or first-time mothers prenatally until the child is four years of age, who are eligible for medical assistance under Minnesota Statutes, chapter 256B, or the federal Special Supplemental Nutrition

Program for Women, Infants, and Children. Priority for grants to rural areas shall be given to community health boards, nonprofits, and tribal nations that expand services within regional partnerships that provide the evidence-based home visiting programs. This funding shall only be used to supplement, not to replace, funds being used for evidence-based home visiting services as of June 30, 2017. Up to seven percent of the appropriation may be used for training, technical assistance, evaluation, and other costs to administer the grants. The general fund base for this program is $16,500,000 in fiscal year 2020 and $16,500,000 in fiscal year 2021.

(d) **Safe Harbor for Sexually Exploited Youth Services.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are from the general fund for trauma-informed, culturally specific services for sexually exploited youth. Youth 24 years of age or younger are eligible for services under this paragraph.

(e) **Safe Harbor Program Technical Assistance and Evaluation.** $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are from the general fund for training, technical assistance, protocol implementation, and evaluation activities related to the safe harbor program. Of these amounts:

(1) $90,000 each fiscal year is for providing training and technical assistance to individuals and organizations that provide safe harbor services and receive funds for that purpose

from the commissioner of human services or commissioner of health;

(2) $90,000 each fiscal year is for protocol implementation, which includes providing technical assistance in establishing best practices-based systems for effectively identifying, interacting with, and referring sexually exploited youth to appropriate resources; and

(3) $20,000 each fiscal year is for program evaluation activities in compliance with Minnesota Statutes, section 145.4718.

(f) **Promoting Safe Harbor Capacity.** In funding services and activities under paragraphs (d) and (e), the commissioner shall emphasize activities that promote capacity-building and development of resources in greater Minnesota.

(g) **Administration of Safe Harbor Program.** $60,000 in fiscal year 2018 and $60,000 in fiscal year 2019 are for administration of the safe harbor for sexually exploited youth program.

(h) **Palliative Care Advisory Council.** $44,000 in fiscal year 2018 and $44,000 in fiscal year 2019 are from the general fund for the Palliative Care Advisory Council under Minnesota Statutes, section 144.059. This is a onetime appropriation.

(i) **Transfer; Minnesota Biomedicine and Bioethics Innovation Grants.** $2,500,000 in fiscal year 2018 is from the general fund for transfer to the Board of Regents of the University of Minnesota for Minnesota

biomedicine and bioethics innovation grants under Minnesota Statutes, section 137.67. The full amount of the appropriation is for grants, and the University of Minnesota shall not use any portion for administrative or monitoring expenses. The steering committee of the University of Minnesota and Mayo Foundation partnership must submit a preliminary report by April 1, 2018, and a final report by April 1, 2019, on all grant activities funded under Minnesota Statutes, section 137.67, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance. This is a onetime appropriation and is available until June 30, 2021.

(j) **Statewide Strategic Plan for Victims of Sex Trafficking.** $73,000 in fiscal year 2018 is from the general fund for the development of a comprehensive statewide strategic plan and report to address the needs of sex trafficking victims statewide. This is a onetime appropriation.

(k) **Home and Community-Based Services Employee Scholarship Program.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are from the general fund for the home and community-based services employee scholarship program under Minnesota Statutes, section 144.1503.

(l) **Comprehensive Advanced Life Support Educational Program.** $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are from the general fund for the comprehensive advanced life support

educational program under Minnesota Statutes, section 144.6062. This is a onetime appropriation.

(m) **Opioid Abuse Prevention.** $1,028,000 in fiscal year 2018 is to establish and evaluate accountable community for health opioid abuse prevention pilot projects. $28,000 of this amount is for administration. This is a onetime appropriation and is available until June 30, 2021.

(n) **Advanced Care Planning.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are from the general fund for a grant to a statewide advanced care planning resource organization that has expertise in convening and coordinating community-based strategies to encourage individuals, families, caregivers, and health care providers to begin conversations regarding end-of-life care choices that express an individual's health care values and preferences and are based on informed health care decisions. Of this amount, $9,000 each year is for administration. This is a onetime appropriation.

(o) **Health Professionals Clinical Training Expansion Grant Program.** $526,000 in fiscal year 2018 and $526,000 in fiscal year 2019 are from the general fund for the primary care and mental health professions clinical training expansion grant program under Minnesota Statutes, section 144.1505. Of this amount, $26,000 each year is for administration.

(p) **Federally Qualified Health Centers.** $500,000 in fiscal year 2018 and $500,000 in

fiscal year 2019 are from the general fund to provide subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269. This is a onetime appropriation.

(q) **Base Level Adjustments.** The general fund base is $87,656,000 in fiscal year 2020 and $87,706,000 in fiscal year 2021. The health care access fund base is $36,858,000 in fiscal year 2020 and $36,258,000 in fiscal year 2021.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	20,928,000	17,339,000
State Government Special Revenue	47,392,000	47,920,000

(a) **Prescribed Pediatric Extended Care Center Licensure Activities.** $64,000 in fiscal year 2018 and $17,000 in fiscal year 2019 are from the state government special revenue fund for licensure of prescribed pediatric extended care centers under Minnesota Statutes, chapter 144H.

(b) **Vulnerable Adults in Health Care Settings.** $1,162,000 in fiscal year 2018 and $2,030,000 in fiscal year 2019 are from the general fund for regulating health care and home care settings. The general fund base for this purpose is $2,401,000 in fiscal year 2020 and $3,405,000 in fiscal year 2021.

(c) **Transfer; Public Health Response Contingency Account.** The commissioner shall transfer $5,000,000 in fiscal year 2018 from the general fund to the public health response contingency account established in Minnesota Statutes, section 144.4199.

(d) **Base Level Adjustment.** The general fund base is $17,710,000 in fiscal year 2020 and $18,714,000 in fiscal year 2021. The state government special revenue fund base is $47,958,000 in fiscal year 2020 and $48,295,000 in fiscal year 2021.

Subd. 4. **Health Operations**	9,463,000	9,835,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 25,002,000**	**$ 23,295,000**

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	565,000	571,000

Base Level Adjustment. The base is $576,000 in fiscal year 2020 and $576,000 in fiscal year 2021.

Subd. 3. **Board of Dentistry**	1,396,000	1,408,000
Subd. 4. **Board of Dietetics and Nutrition Practice**	130,000	132,000
Subd. 5. **Board of Marriage and Family Therapy**	360,000	357,000

Base Level Adjustment. The base is $360,000 in fiscal year 2020 and $361,000 in fiscal year 2021.

Subd. 6. **Board of Medical Practice**	5,193,000	5,329,000

(a) **Health Professional Services Program.** This appropriation includes $955,000 in fiscal year 2018 and $964,000 in fiscal year 2019 for the health professional services program. The base for this program is $924,000 in fiscal year 2020 and $924,000 in fiscal year 2021.

(b) **Base Level Adjustment.** The base is $5,291,000 in fiscal year 2020 and $5,291,000 in fiscal year 2021.

Subd. 7. **Board of Nursing**	6,380,000	4,783,000
Subd. 8. **Board of Nursing Home Administrators**	3,397,000	3,202,000

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $2,260,000 in fiscal year 2018 and $2,287,000 in fiscal year 2019 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 2018 and $150,000 in fiscal year 2019 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $378,000 in fiscal year 2018 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 - Health-Related Licensing Boards Operating Costs.** Of this appropriation, $194,000 in fiscal year 2018 and $350,000 in fiscal year 2019 shall be transferred to the health-related boards funded under this section for operating costs. The administrative services unit shall determine transfer amounts in consultation with the health-related boards funded under this section.

(e) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 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 money 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**	173,000	174,000

Subd. 10. **Board of Pharmacy** 3,124,000 3,164,000

Base Level Adjustment. The base is $3,189,000 in fiscal year 2020 and $3,226,000 in fiscal year 2021.

Subd. 11. **Board of Physical Therapy** 521,000 522,000

Base Level Adjustment. The base is $524,000 in fiscal year 2020 and $526,000 in fiscal year 2021.

Subd. 12. **Board of Podiatric Medicine** 204,000 204,000

Subd. 13. **Board of Psychology** 1,220,000 1,240,000

Base Level Adjustment. The base is $1,247,000 in fiscal year 2020 and $1,247,000 in fiscal year 2021.

Subd. 14. **Board of Social Work** 1,254,000 1,246,000

Base Level Adjustment. The base is $1,248,000 in fiscal year 2020 and $1,250,000 in fiscal year 2021.

Subd. 15. **Board of Veterinary Medicine** 314,000 320,000

Base Level Adjustment. The base is $327,000 in fiscal year 2020 and $333,000 in fiscal year 2021.

Subd. 16. **Board of Behavioral Health and Therapy** 771,000 643,000

Subd. 17. **Board of Occupational Therapy Practice** 374,000 328,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$** **3,667,000** **$** **3,596,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2018 and $950,000 in fiscal year 2019 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2018 and $861,000 in fiscal year 2019 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 2018 and $89,000 in fiscal year 2019 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $1,771,000 in fiscal year 2018 and $1,700,000 in fiscal year 2019 are for board operations. The base for this program is $1,702,000 in fiscal year 2020 and $1,702,000 in fiscal year 2021.

(c) **Regional Grants.** $585,000 in fiscal year 2018 and $585,000 in fiscal year 2019 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.** $361,000 in fiscal year 2018 and $361,000 in fiscal year 2019 are for training grants under Minnesota Statutes, section 144E.35.

(e) **Base Level Adjustment.** The base is $3,598,000 in fiscal year 2020 and $3,598,000 in fiscal year 2021.

Sec. 6. **COUNCIL ON DISABILITY** **$ 893,000 $ 892,000**

Base Level Adjustment. The base is $856,000 in fiscal year 2020 and $858,000 in fiscal year 2021.

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,407,000 $ 2,427,000**

Department of Psychiatry Monitoring.

$100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 460,000 $ 465,000**

Sec. 9. Laws 2009, chapter 101, article 1, section 12, is amended to read:

Sec. 12. **ADMINISTRATION**

Subdivision 1. **Total Appropriation** **$ 19,973,000 $ 19,617,000**

Appropriations by Fund

	2010	2011
General	19,723,000	19,617,000
Special Revenue Fund	250,000	0

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Government and Citizen Services** 18,097,000 17,766,000

Appropriations by Fund

General	17,847,000	17,766,000
Special Revenue Fund	250,000	0

(a) $802,000 the first year and $802,000 the second year are for the Minnesota Geospatial Information Office. Of the total appropriation, $10,000 per year is intended for preparation of township acreage data in Laws 2008, chapter 366, article 17, section 7, subdivision 3.

(b) $74,000 the first year and $74,000 the second year are for the Council on Developmental Disabilities.

~~(c) $127,000 the first year and $127,000 the second year are for transfer to the commissioner of human services for a grant to the Council on Developmental Disabilities for the purpose of establishing a statewide self-advocacy network for persons with intellectual and developmental disabilities (ID/DD). The self-advocacy network shall: (1) ensure that persons with ID/DD are informed of their rights in employment, housing, transportation, voting, government policy, and other issues pertinent to the ID/DD community; (2) provide public education and awareness of the civil and human rights issues persons with ID/DD face; (3) provide funds, technical assistance, and other resources for self-advocacy groups across the state; and (4) organize systems of communications to facilitate an exchange of information between self-advocacy groups. This appropriation must be included in the base budget for the commissioner of human services for the biennium beginning July 1, 2011.~~

(d) $250,000 the first year and $170,000 the second year are to fund activities to prepare for and promote the 2010 census.

(e) $206,000 the first year and $206,000 the second year are for the Office of the State Archaeologist.

(f) $8,388,000 the first year and $8,388,000 the second year are for office space costs of the legislature and veterans organizations, for

ceremonial space, and for statutorily free space.

(g) $3,500,000 of the balance in the facilities repair and replacement account in the special revenue fund is canceled to the general fund on July 1, 2009. This is a onetime cancellation.

(h) The requirements imposed on the commissioner of finance and the commissioner of administration under Laws 2007, chapter 148, article 1, section 12, subdivision 2, paragraph (b), relating to the savings attributable to the real property portfolio management system are inoperative.

(i) $250,000 is appropriated to the commissioner of administration from the information and telecommunications account in the special revenue fund to continue planning for data center consolidation, including beginning a predesign study and lifecycle cost analysis, and exploring technologies to reduce energy consumption and operating costs.

Subd. 3. **Administrative Management Support**		1,876,000	1,851,000

$125,000 each year is for the Office of Grant Management. During the biennium ending June 30, 2011, the commissioner must recover this amount through deductions in state grants subject to the jurisdiction of the office. The commissioner may not deduct more than 2.5 percent from the amount of any grant. The amount deducted from appropriations for these grants must be deposited in the general fund.

$25,000 the first year is for the Office of Grants Management to study and make

recommendations on improving collaborative activities between the state, nonprofit entities, and the private sector, including: (1) recommendations for expanding successful initiatives involving not-for-profit organizations that have demonstrated measurable, positive results in addressing high-priority community issues; and (2) recommendations on grant requirements and design to encourage programs receiving grants to become self-sufficient. The office may appoint an advisory group to assist in the study and recommendations. The office must report its recommendations to the legislature by January 15, 2010.

Sec. 10. Laws 2012, chapter 247, article 6, section 2, subdivision 2, is amended to read:

Subd. 2. **Central Office Operations**

(a) **Operations**	118,000	356,000
Base Level Adjustment. The general fund base is increased by $91,000 in fiscal year 2014 and $44,000 in fiscal year 2015.		
(b) **Health Care**	24,000	346,000

This is a onetime appropriation.

Managed Care Audit Activities. In fiscal year 2014, ~~and in each even-numbered year thereafter,~~ the commissioner shall transfer from the health care access fund $1,740,000 to the legislative auditor for managed care audit services under Minnesota Statutes, section 256B.69, subdivision 9d. This is a biennial appropriation. The health care access fund base is increased by $1,842,000 in fiscal year 2014. ~~Notwithstanding any contrary~~

~~provision in this article, this paragraph does not expire.~~

(c) **Continuing Care** 19,000 375,000

Base Level Adjustment. The general fund base is decreased by $159,000 in fiscal years 2014 and 2015.

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

Sec. 11. Laws 2013, chapter 108, article 15, section 2, subdivision 2, is amended to read:

Subd. 2. **Central Office**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Operations 2,909,000 8,957,000

Base Adjustment. The general fund base is decreased by $8,916,000 in fiscal year 2016 and $8,916,000 in fiscal year 2017.

(b) Children and Families 109,000 206,000

(c) Continuing Care 2,849,000 3,574,000

Base Adjustment. The general fund base is decreased by $2,000 in fiscal year 2016 and by $27,000 in fiscal year 2017.

(d) Group Residential Housing (1,166,000) (8,602,000)

(e) Medical Assistance (3,950,000) (6,420,000)

(f) Alternative Care (7,386,000) (6,851,000)

(g) Child and Community Service Grants 3,000,000 3,000,000

(h) Aging and Adult Services Grants 5,365,000 5,936,000

~~**Gaps Analysis.** In fiscal year 2014, and in each even-numbered year thereafter, $435,000 is appropriated to conduct an analysis of gaps in long-term care services under Minnesota Statutes, section 144A.351. This is a biennial appropriation. The base is increased by $435,000 in fiscal year 2016. Notwithstanding~~

~~any contrary provisions in this article, this provision does not expire.~~

Base Adjustment. The general fund base is increased by $498,000 in fiscal year 2016, and decreased by $124,000 in fiscal year 2017.

(i) Disabilities Grants	414,000	414,000

Sec. 12. Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended by Laws 2015, First Special Session chapter 6, section 2, is amended to read:

Subd. 2. **Health Improvement**

	Appropriations by Fund	
General	68,653,000	68,984,000
State Government Special Revenue	6,264,000	6,182,000
Health Care Access	33,987,000	33,421,000
Federal TANF	11,713,000	11,713,000

Violence Against Asian Women Working Group. $200,000 in fiscal year 2016 from the general fund is for the working group on violence against Asian women and children.

MERC Program. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for the MERC program under Minnesota Statutes, section 62J.692, subdivision 4.

Poison Information Center Grants. $750,000 in fiscal year 2016 and $750,000 in fiscal year 2017 are from the general fund for regional poison information center grants under Minnesota Statutes, section 145.93.

Advanced Care Planning. $250,000 in fiscal year 2016 is from the general fund to award a grant to a statewide advance care planning resource organization that has expertise in convening and coordinating community-based

strategies to encourage individuals, families, caregivers, and health care providers to begin conversations regarding end-of-life care choices that express an individual's health care values and preferences and are based on informed health care decisions. This is a onetime appropriation.

Early Dental Prevention Initiatives. $172,000 in fiscal year 2016 and $140,000 in fiscal year 2017 are for the development and distribution of the early dental prevention initiative under Minnesota Statutes, section 144.3875.

International Medical Graduate Assistance Program. (a) $500,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the health care access fund for the grant programs and necessary contracts under Minnesota Statutes, section 144.1911, subdivisions 3, paragraph (a), clause (4), and 4 and 5. The commissioner may use up to $133,000 per year of the appropriation for international medical graduate assistance program administration duties in Minnesota Statutes, section 144.1911, subdivisions 3, 9, and 10, and for administering the grant programs under Minnesota Statutes, section 144.1911, subdivisions 4, 5, and 6. The commissioner shall develop recommendations for any additional funding required for initiatives needed to achieve the objectives of Minnesota Statutes, section 144.1911. The commissioner shall report the funding recommendations to the legislature by January 15, 2016, in the report required under Minnesota Statutes,

section 144.1911, subdivision 10. The base for this purpose is $1,000,000 in fiscal years 2018 and 2019.

(b) $500,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the health care access fund for transfer to the revolving international medical graduate residency account established in Minnesota Statutes, section 144.1911, subdivision 6. This is a onetime appropriation.

Federally Qualified Health Centers. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund to provide subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269. This is a onetime appropriation.

Organ Donation. $200,000 in fiscal year 2016 is from the general fund to establish a grant program to develop and create culturally appropriate outreach programs that provide education about the importance of organ donation. Grants shall be awarded to a federally designated organ procurement organization and hospital system that performs transplants. This is a onetime appropriation.

Primary Care Residency. $1,500,000 in fiscal year 2016 and $1,500,000 in fiscal year 2017 are from the general fund for the purposes of the primary care residency expansion grant program under Minnesota Statutes, section 144.1506.

Somali ~~Women's Health Pilot~~ Autism Program. ~~(a)~~ The commissioner of health

shall ~~establish a pilot program between one or more federally qualified health centers, as defined under Minnesota Statutes, section 145.9269, a nonprofit organization that helps Somali women, and the Minnesota Evaluation Studies Institute, to develop a promising strategy to address the preventative and primary health care needs of, and address health inequities experienced by, first generation Somali women. The pilot program must collaboratively develop a patient flow process for first generation Somali women by:~~

~~(1) addressing and identifying clinical and cultural barriers to Somali women accessing preventative and primary care, including, but not limited to, cervical and breast cancer screenings;~~

~~(2) developing a culturally appropriate health curriculum for Somali women based on the outcomes from the community-based participatory research report "Cultural Traditions and the Reproductive Health of Somali Refugees and Immigrants" to increase the health literacy of Somali women and develop culturally specific health care information; and~~

~~(3) training the federally qualified health center's providers and staff to enhance provider and staff cultural competence regarding the cultural barriers, including female genital cutting.~~

~~(b) The pilot program must develop a process that results in increased screening rates for cervical and breast cancer and can be replicated by other providers serving ethnic~~

~~minorities. The pilot program must conduct an evaluation of the new patient flow process used by Somali women to access federally qualified health centers services~~ award a grant to Dakota County to partner with a community-based organization with expertise in serving Somali children with autism. The grant must address barriers to accessing health care and other resources by providing outreach to Somali families on available support and training to providers on Somali culture.

(c) ~~The pilot program must report the outcomes to the commissioner by June 30, 2017.~~ The grantee shall report to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance on the grant funds used and any notable outcomes achieved by January 15, 2019.

(d) $110,000 in fiscal year 2016 is for the ~~Somali women's health pilot program~~ grant to Dakota County. Of this appropriation, the commissioner may use up to $10,000 to administer the ~~program~~ grant to Dakota County. This appropriation is available until June 30, 2017. This is a onetime appropriation.

Menthol Cigarette Usage in African-American Community Intervention Grants. Of the health care access fund appropriation for the statewide health improvement program, $200,000 in fiscal year 2016 is for at least one grant that must be awarded by the commissioner to implement strategies and interventions to reduce the

disproportionately high usage of cigarettes by African-Americans, especially the use of menthol-flavored cigarettes, as well as the disproportionate harm tobacco causes in that community. The grantee shall engage members of the African-American community and community-based organizations. This grant shall be awarded as part of the statewide health improvement program grants awarded on November 1, 2015, and must meet the requirements of Minnesota Statutes, section 145.986.

Targeted Home Visiting System. (a) $75,000 in fiscal year 2016 is for the commissioner of health, in consultation with the commissioners of human services and education, community health boards, tribal nations, and other home visiting stakeholders, to design baseline training for new home visitors to ensure statewide coordination across home visiting programs.

(b) $575,000 in fiscal year 2016 and $2,000,000 fiscal year 2017 are to provide grants to community health boards and tribal nations for start-up grants for new nurse-family partnership programs and for grants to expand existing programs to serve first-time mothers, prenatally by 28 weeks gestation until the child is two years of age, who are eligible for medical assistance under Minnesota Statutes, chapter 256B, or the federal Special Supplemental Nutrition Program for Women, Infants, and Children. The commissioner shall award grants to community health boards or tribal nations in

metropolitan and rural areas of the state. Priority for all grants shall be given to nurse-family partnership programs that provide services through a Minnesota health care program-enrolled provider that accepts medical assistance. Additionally, priority for grants to rural areas shall be given to community health boards and tribal nations that expand services within regional partnerships that provide the nurse-family partnership program. Funding available under this paragraph may only be used to supplement, not to replace, funds being used for nurse-family partnership home visiting services as of June 30, 2015.

Opiate Antagonists. $270,000 in fiscal year 2016 and $20,000 in fiscal year 2017 are from the general fund for grants to the eight regional emergency medical services programs to purchase opiate antagonists and educate and train emergency medical services persons, as defined in Minnesota Statutes, section 144.7401, subdivision 4, clauses (1) and (2), in the use of these antagonists in the event of an opioid or heroin overdose. For the purposes of this paragraph, "opiate antagonist" means naloxone hydrochloride or any similarly acting drug approved by the federal Food and Drug Administration for the treatment of drug overdose. Grants under this paragraph must be distributed to all eight regional emergency medical services programs. This is a onetime appropriation and is available until June 30, 2017. The commissioner may use up to $20,000 of the amount for opiate antagonists for administration.

Local and Tribal Public Health Grants. (a) $894,000 in fiscal year 2016 and $894,000 in fiscal year 2017 are for an increase in local public health grants for community health boards under Minnesota Statutes, section 145A.131, subdivision 1, paragraph (e).

(b) $106,000 in fiscal year 2016 and $106,000 in fiscal year 2017 are for an increase in special grants to tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a.

HCBS Employee Scholarships. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for the home and community-based services employee scholarship program under Minnesota Statutes, section 144.1503. The commissioner may use up to $50,000 of the amount for the HCBS employee scholarships for administration.

Family Planning Special Projects. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for family planning special project grants under Minnesota Statutes, section 145.925.

Positive Alternatives. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for positive abortion alternatives under Minnesota Statutes, section 145.4235.

Safe Harbor for Sexually Exploited Youth. $700,000 in fiscal year 2016 and $700,000 in fiscal year 2017 are from the general fund for the safe harbor program under Minnesota

Statutes, sections 145.4716 to 145.4718. Funds shall be used for grants to increase the number of regional navigators; training for professionals who engage with exploited or at-risk youth; implementing statewide protocols and best practices for effectively identifying, interacting with, and referring sexually exploited youth to appropriate resources; and program operating costs.

Health Care Grants for Uninsured Individuals. (a) $62,500 in fiscal year 2016 and $62,500 in fiscal year 2017 are from the health care access fund for dental provider grants in Minnesota Statutes, section 145.929, subdivision 1.

(b) $218,750 in fiscal year 2016 and $218,750 in fiscal year 2017 are from the health care access fund for community mental health program grants in Minnesota Statutes, section 145.929, subdivision 2.

(c) $750,000 in fiscal year 2016 and $750,000 in fiscal year 2017 are from the health care access fund for the emergency medical assistance outlier grant program in Minnesota Statutes, section 145.929, subdivision 3.

(d) $218,750 of the health care access fund appropriation in fiscal year 2016 and $218,750 in fiscal year 2017 are for community health center grants under Minnesota Statutes, section 145.9269. A community health center that receives a grant from this appropriation is not eligible for a grant under paragraph (b).

(e) The commissioner may use up to $25,000 of the appropriations for health care grants for

uninsured individuals in fiscal years 2016 and 2017 for grant administration.

TANF Appropriations. (a) $1,156,000 of the TANF funds is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(b) $3,579,000 of the TANF funds is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed 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.

(c) $2,000,000 of the TANF funds is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(d) $4,978,000 of the TANF funds is appropriated each year of the biennium to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments as provided in Minnesota Statutes, section 145A.14, subdivision 2a.

(e) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal

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.

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.

Health Professional Loan Forgiveness. $2,631,000 in fiscal year 2016 and $2,631,000 in fiscal year 2017 are from the health care access fund for the purposes of Minnesota Statutes, section 144.1501. Of this appropriation, the commissioner may use up to $131,000 each year to administer the program.

Minnesota Stroke System. $350,000 in fiscal year 2016 and $350,000 in fiscal year 2017 are from the general fund for the Minnesota stroke system.

Prevention of Violence in Health Care. $50,000 in fiscal year 2016 is to continue the prevention of violence in health care program and creating violence prevention resources for hospitals and other health care providers to use in training their staff on violence prevention. This is a onetime appropriation and is available until June 30, 2017.

Health Care Savings Determinations. (a) The health care access fund base for the state health improvement program is decreased by

$261,000 in fiscal year 2016 and decreased by $110,000 in fiscal year 2017.

(b) $261,000 in fiscal year 2016 and $110,000 in fiscal year 2017 are from the health care access fund for the forecasting, cost reporting, and analysis required by Minnesota Statutes, section 62U.10, subdivisions 6 and 7.

Base Level Adjustments. The general fund base is decreased by $1,070,000 in fiscal year 2018 and by $1,020,000 in fiscal year 2019. The state government special revenue fund base is increased by $33,000 in fiscal year 2018. The health care access fund base is increased by $610,000 in fiscal year 2018 and by $23,000 in fiscal year 2019.

Sec. 13. Laws 2017, chapter 2, article 1, section 2, subdivision 3, is amended to read:

Subd. 3. **Payments to health carriers.** (a) The commissioner shall make payments to health carriers on behalf of eligible individuals effectuating coverage for calendar year 2017, for the months in that year for which the individual has paid the net premium amount to the health carrier. Payments to health carriers shall be based on the premium subsidy available to eligible individuals in the individual market, regardless of the cost of coverage purchased. The commissioner shall not withhold payments because a health carrier cannot prove an enrollee is an eligible individual.

(b) Health carriers seeking reimbursement from the commissioner must submit an invoice and supporting information to the commissioner, using a form developed by the commissioner, in order to be eligible for payment. The commissioner shall finalize the form by March 1, 2017.

(c) Total state payments to health carriers must be made within the limits of the available appropriation. The commissioner shall reimburse health carriers at the full requested amount up to the level of the appropriation. The commissioner, by July 15, 2017, shall determine whether the available appropriation will be sufficient to provide premium subsidies equal to 25 percent of the gross premium for the period September 1, 2017, through December 31, 2017. If the commissioner determines that the available appropriation is not sufficient, the commissioner shall reduce the premium subsidy percentage, beginning September 1,

2017, through the remainder of the calendar year, by an amount sufficient to ensure that the total amount of premium subsidies provided for the calendar year does not exceed the available appropriation. The commissioner shall notify health carriers of any reduced premium subsidy percentage within five days of making a determination. Health carriers shall provide enrollees with at least 30 days' notice of any reduction in the premium subsidy percentage.

(d) The commissioner shall consider health carriers as vendors under Minnesota Statutes, section 16A.124, subdivision 3, and each monthly invoice shall represent the completed delivery of the service.

(e) The commissioner, with the November 2017 forecast, shall certify the extent to which appropriations exceed forecast obligations under this subdivision. Notwithstanding Laws 2017, chapter 2, article 1, section 7, the estimated value of available funds, up to $98,779,000, shall be canceled to the general fund. The cancellation in this paragraph shall be reduced by any difference in medical assistance expenditures estimated in the trend calculation under section 15.

Sec. 14. **IMPLEMENTATION OF CONTINGENT APPROPRIATIONS.**

Notwithstanding Laws 2017, chapter 2, article 1, section 7, and upon certification of excess funds in accordance with Laws 2017, chapter 2, article 1, section 2, subdivision 3, up to $1,388,000 in fiscal year 2018 and up to $15,102,000 in fiscal year 2019 are appropriated to the commissioner of human services for central office operations in fiscal year 2019. This appropriation is onetime.

Sec. 15. **TREND LIMIT; CALCULATION.**

Beginning January 1, 2019, and ending June 30, 2021, the commissioner may limit the trend increase in rates paid to managed care plans and county-based purchasing plans under Minnesota Statutes, sections 256B.69 and 256B.692, by an amount equal to the value of a 0.5 percent reduction in trend in medical assistance. Managed care rates must meet actuarial soundness and rate development requirements under Code of Federal Regulations, title 42, part 438, subpart A.

In the November 2017 forecast, the commissioner of human services, in consultation with the commissioner of management and budget, shall determine the extent to which the limits in managed care trend growth are forecasted to reduce medical assistance expenditures in fiscal years 2019 through 2021. Any reduction estimated shall reduce the cancellation in Laws 2017, chapter 2, article 1, section 2, subdivision 3, paragraph (e), by up to $82,289,000.

Sec. 16. **TRANSFERS.**

Subdivision 1. **Grants.** 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, 2019, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing programs, 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 and Policy Committee, the senate Human Services Reform Finance and Policy Committee, and the house of representatives Health and Human Services Finance Committee 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 and Policy Committee, the senate Human Services Reform Finance and Policy Committee, and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 17. **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. 18. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2019, unless a different expiration date is explicit.

Sec. 19. **EFFECTIVE DATE.**

This article is effective July 1, 2017, unless a different effective date is specified.

APPENDIX
Article locations in 17-4723

13.468 DATA SHARING WITHIN COUNTIES.

County welfare, human services, corrections, public health, and veterans service units within a county may inform each other as to whether an individual or family currently is being served by the county unit, without the consent of the subject of the data. Data that may be shared are limited to the following: the name, telephone number, and last known address of the data subject; and the identification and contact information regarding personnel of the county unit responsible for working with the individual or family. If further information is necessary for the county unit to carry out its duties, each county unit may share additional data if the unit is authorized by state statute or federal law to do so or the individual gives written, informed consent.

103I.005 DEFINITIONS.

Subd. 8. **Environmental bore hole.** "Environmental bore hole" means a hole or excavation in the ground that penetrates a confining layer or is greater than 25 feet in depth and enters or goes through a water bearing layer and is used to monitor or measure physical, chemical, radiological, or biological parameters without extracting water. An environmental bore hole also includes bore holes constructed for vapor recovery or venting systems. An environmental bore hole does not include a well, elevator shaft, exploratory boring, or monitoring well.

Subd. 14. **Monitoring well.** "Monitoring well" means an excavation that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed to extract groundwater for physical, chemical, or biological testing. "Monitoring well" includes a groundwater quality sampling well.

Subd. 15. **Monitoring well contractor.** "Monitoring well contractor" means a person who is registered by the commissioner to construct monitoring wells.

103I.451 ENVIRONMENTAL BORE HOLES.

An environmental bore hole must be constructed, sealed, and reported as prescribed by rule of the commissioner by a well contractor or a monitoring well contractor.

119B.07 USE OF MONEY.

(a) Money for persons listed in sections 119B.03, subdivision 3, and 119B.05, subdivision 1, shall be used to reduce the costs of child care for students, including the costs of child care for students while employed if enrolled in an eligible education program at the same time and making satisfactory progress towards completion of the program. Counties may not limit the duration of child care subsidies for a person in an employment or educational program, except when the person is found to be ineligible under the child care fund eligibility standards. Any limitation must be based on a person's employment plan in the case of an MFIP participant, and county policies included in the child care fund plan. The maximum length of time a student is eligible for child care assistance under the child care fund for education and training is no more than the time necessary to complete the credit requirements for an associate or baccalaureate degree as determined by the educational institution, excluding basic or remedial education programs needed to prepare for postsecondary education or employment.

(b) To be eligible, the student must be in good standing and be making satisfactory progress toward the degree. Time limitations for child care assistance do not apply to basic or remedial educational programs needed to prepare for postsecondary education or employment. These programs include: high school, general equivalency diploma, and English as a second language. Programs exempt from this time limit must not run concurrently with a postsecondary program. If an MFIP participant who is receiving MFIP child care assistance under this chapter moves to another county, continues to participate in educational or training programs authorized in their employment plans, and continues to be eligible for MFIP child care assistance under this chapter, the MFIP participant must receive continued child care assistance from the county responsible for their current employment plan, under section 256G.07.

144.0571 INCLUSION OF OTHER HEALTH-RELATED OCCUPATIONS TO CRIMINAL BACKGROUND CHECKS.

(a) If the Department of Health is not reviewed by the Sunset Advisory Commission according to the schedule in section 3D.21, the commissioner of health, as the regulator for occupational therapy practitioners, speech-language pathologists, audiologists, and hearing instrument dispensers, shall require applicants for licensure or renewal to submit to a criminal

history records check as required under section 214.075 for other health-related licensed occupations regulated by the health-related licensing boards.

(b) Any statutory changes necessary to include the commissioner of health to section 214.075 shall be included in the plan required in section 214.075, subdivision 8.

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

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

147A.21 RULEMAKING AUTHORITY.

The board shall adopt rules:

(1) setting license fees;

(2) setting renewal fees;

(3) setting fees for temporary licenses; and

(4) establishing renewal dates.

147B.08 FEES.

Subdivision 1. **Annual registration fee.** The board shall establish the fee of $150 for initial licensure and $150 annual licensure renewal. The board may prorate the initial licensure fee.

Subd. 2. **Penalty fee for late renewals.** The penalty fee for late submission for renewal application is $50.

Subd. 3. **Deposit.** Fees collected by the board under this section must be deposited in the state government special revenue fund.

147C.40 FEES.

Subdivision 1. **Fees.** The board shall adopt rules setting:

(1) licensure fees;

(2) renewal fees;

(3) late fees;

(4) inactive status fees; and

(5) fees for temporary permits.

Subd. 2. **Proration of fees.** The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal.

Subd. 3. **Penalty fee for late renewals.** An application for license renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

148.6402 DEFINITIONS.

Subd. 2. **Advisory council.** "Advisory council" means the Occupational Therapy Practitioners Advisory Council in section 148.6450.

148.6450 OCCUPATIONAL THERAPY PRACTITIONERS ADVISORY COUNCIL.

Subdivision 1. **Membership.** The commissioner shall appoint seven persons to an Occupational Therapy Practitioners Advisory Council consisting of the following:

(1) two public members, as defined in section 214.02. The public members shall be either persons who have received occupational therapy services or family members of or caregivers to such persons;

(2) two members who are occupational therapists and two occupational therapy assistants licensed under sections 148.6401 to 148.6450, each of whom is employed in a different practice area including, but not limited to, long-term care, school therapy, early intervention, administration, gerontology, industrial rehabilitation, cardiac rehabilitation, physical disability,

pediatrics, mental health, home health, and hand therapy. Three of the four occupational therapy practitioners who serve on the advisory council must be currently, and for the three years preceding the appointment, engaged in the practice of occupational therapy or employed as an administrator or an instructor of an occupational therapy program. At least one of the four occupational therapy practitioners who serves on the advisory council must be employed in a rural area; and

(3) one member who is a licensed or registered health care practitioner, or other credentialed practitioner, who works collaboratively with occupational therapy practitioners.

Subd. 2. **Duties.** At the commissioner's request, the advisory council shall:

(1) advise the commissioner regarding the occupational therapy practitioner licensure standards;

(2) advise the commissioner on enforcement of sections 148.6401 to 148.6450;

(3) provide for distribution of information regarding occupational therapy practitioners licensure standards;

(4) review applications and make recommendations to the commissioner on granting or denying licensure or licensure renewal;

(5) review reports of investigations relating to individuals and make recommendations to the commissioner as to whether licensure should be denied or disciplinary action taken against the person; and

(6) perform other duties authorized for advisory councils by chapter 214, as directed by the commissioner.

148.906 LEVELS OF PRACTICE.

The board may grant licenses for levels of psychological practice to be known as (1) licensed psychologist and (2) licensed psychological practitioner.

148.907 LICENSED PSYCHOLOGIST.

Subd. 5. **Converting from licensed psychological practitioner to licensed psychologist.** Notwithstanding subdivision 3, to convert from licensure as a licensed psychological practitioner to licensure as a licensed psychologist, a licensed psychological practitioner shall have:

(1) completed an application provided by the board for conversion from licensure as a licensed psychological practitioner to licensure as a licensed psychologist;

(2) paid a nonrefundable fee of $500;

(3) documented successful completion of two full years, or the equivalent, of supervised postlicensure employment meeting the requirements of section 148.925, subdivision 5, as it relates to preparation for licensure as a licensed psychologist as follows:

(i) for individuals licensed as licensed psychological practitioners on or before December 31, 2006, the supervised practice must be completed by December 31, 2010; and

(ii) for individuals licensed as licensed psychological practitioners after December 31, 2006, the supervised practice must be completed within four years from the date of licensure; and

(4) no unresolved disciplinary action or complaints pending, or incomplete disciplinary orders or corrective action agreements in Minnesota or any other jurisdiction.

148.908 LICENSED PSYCHOLOGICAL PRACTITIONER.

Subdivision 1. **Scope of practice.** A licensed psychological practitioner shall practice only under supervision that satisfies the requirements of section 148.925 and while employed by either a licensed psychologist or a health care or social service agency which employs or contracts with a supervising licensed psychologist who shares clinical responsibility for the care provided by the licensed psychological practitioner.

Subd. 2. **Requirements for licensure as licensed psychological practitioner.** To become licensed by the board as a licensed psychological practitioner, an applicant shall comply with the following requirements:

(1) have earned a doctoral or master's degree or the equivalent of a master's degree in a doctoral program with a major in psychology from a regionally accredited educational institution meeting the standards the board has established by rule. The degree requirements must be completed by December 31, 2005;

(2) complete an application for admission to the examination for professional practice in psychology and pay the nonrefundable application fee by December 31, 2005;

(3) complete an application for admission to the professional responsibility examination and pay the nonrefundable application fee by December 31, 2005;

(4) pass the examination for professional practice in psychology by December 31, 2006;

(5) pass the professional responsibility examination by December 31, 2006;

(6) complete an application for licensure as a licensed psychological practitioner and pay the nonrefundable application fee by March 1, 2007; and

(7) have attained the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction.

Subd. 3. **Termination of licensure.** Effective December 31, 2011, the licensure of all licensed psychological practitioners shall be terminated without further notice and licensure as a licensed psychological practitioner in Minnesota shall be eliminated.

148.909 LICENSURE FOR VOLUNTEER PRACTICE.

Subd. 7. **Continuing education requirements.** A provider licensed under this section is subject to the same continuing education requirements as a licensed psychologist under section 148.911.

148.96 PRESENTATION TO PUBLIC.

Subd. 4. **Persons or techniques not regulated by this board.** (a) Nothing in sections 148.88 to 148.98 shall be construed to limit the occupational pursuits consistent with their training and codes of ethics of professionals such as teachers in recognized public and private schools, members of the clergy, physicians, social workers, school psychologists, alcohol or drug counselors, optometrists, or attorneys. However, in such performance any title used shall be in accordance with section 148.96.

(b) Use of psychological techniques by business and industrial organizations for their own personnel purposes or by employment agencies or state vocational rehabilitation agencies for the evaluation of their own clients prior to recommendation for employment is also specifically allowed. However, no representative of an industrial or business firm or corporation may sell, offer, or provide any psychological services as specified in section 148.89 unless such services are performed or supervised by individuals licensed under sections 148.88 to 148.98.

Subd. 5. **Other professions not authorized.** Nothing in sections 148.88 to 148.98 shall be construed to authorize a person licensed under sections 148.88 to 148.98 to engage in the practice of any profession regulated under Minnesota law unless the person is duly licensed or registered in that profession.

245A.1915 OPIOID ADDICTION TREATMENT EDUCATION REQUIREMENT FOR PROVIDERS LICENSED TO PROVIDE CHEMICAL DEPENDENCY TREATMENT SERVICES.

All programs serving persons with substance use issues licensed by the commissioner must provide educational information concerning: treatment options for opioid addiction, including the use of a medication for the use of opioid addiction; and recognition of and response to opioid overdose and the use and administration of naloxone, to clients identified as having or seeking treatment for opioid addiction. The commissioner shall develop educational materials that are supported by research and updated periodically that must be used by programs to comply with this requirement.

245A.192 PROVIDERS LICENSED TO PROVIDE TREATMENT OF OPIOID ADDICTION.

Subdivision 1. **Scope.** (a) This section applies to services licensed under this chapter to provide treatment for opioid addiction. In addition to the requirements under Minnesota Rules, parts 9530.6405 to 9530.6505, a program licensed to provide treatment of opioid addiction must meet the requirements in this section.

(b) Where a standard in this section differs from a standard in an otherwise applicable administrative rule, the standards of this section apply.

(c) When federal guidance or interpretations have been issued on federal standards or requirements also required under this section, the federal guidance or interpretations shall apply.

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 its intended use.

(c) "Guest dose or dosing" means the practice of administering 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, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director's direct supervision.

(e) "Medication used for the treatment of opioid addiction" means a medication approved by the Food and Drug Administration for the treatment of opioid addiction.

(f) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under Minnesota Rules, part 9530.6500.

(g) "Program" means an entity that is licensed under Minnesota Rules, part 9530.6500.

(h) "Unsupervised use" means the use of a medication for the treatment of opioid addiction dispensed for use by a client outside of the program setting. This is also referred to as a "take-home" dose.

(i) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(j) "Minnesota health care programs" has the meaning given in section 256B.0636.

Subd. 3. **Medication orders.** Prior to the program administering or dispensing a medication used for the treatment of opioid addiction:

(1) a client-specific order must be received from an appropriately credentialed physician 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 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 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 patient's health, as determined by the medical director.

Subd. 3a. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 5, 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. The meeting must occur before the administering or dispensing of the increased dose.

Subd. 4. **Drug testing.** Each client enrolled in the program must receive a minimum of eight random drug abuse tests per 12 months of treatment. These tests must be reasonably disbursed over the 12-month period. A license holder may elect to conduct more drug abuse tests.

Subd. 5. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid addiction to the illicit market, any such medications dispensed to patients for unsupervised use shall be subject to the following requirements:

(1) any patient in an opioid treatment program may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and state and federal holidays; and

(2) treatment program decisions on dispensing medications used to treat opioid addiction to patients for unsupervised use beyond that set forth in clause (1) shall be determined by the medical director.

(b) A physician with authority to prescribe must consider the criteria in this subdivision in determining whether a client may be permitted unsupervised or take-home use of such medications. The criteria must also be considered when determining whether dispensing medication for a client's unsupervised use is appropriate to increase or to extend the amount of time between visits to the program. The criteria include:

(1) absence of recent abuse of drugs including but not limited to opioids, nonnarcotics, 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 take-home 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 consistent with the criteria in this subdivision and must be documented in the client's medical record.

Subd. 6. **Restrictions for unsupervised or take-home use of methadone hydrochloride.** (a) In cases where it is determined that a client meets the criteria in subdivision 5 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in paragraphs (b) to (g) must be followed when the medication to be dispensed is methadone hydrochloride.

(b) During the first 90 days of treatment, the take-home 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 take-home supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the take-home 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 supply of take-home medication.

(f) After one year of continuous treatment, a client may be given a maximum two-week supply of take-home medication.

(g) After two years of continuous treatment, a client may be given a maximum one-month supply of take-home medication, but must make monthly visits.

Subd. 7. **Restriction exceptions.** When a license holder has reason to accelerate the number of unsupervised or take-home doses of methadone hydrochloride, the license holder must comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the criteria for unsupervised use in subdivision 5, and must use the exception process provided by the federal Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the purposes of enforcement of this subdivision, the commissioner has the authority to monitor for compliance with these federal regulations and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 8. **Guest dosing.** In order to receive a guest dose, the client must be enrolled in an opioid treatment program elsewhere in the state or country and be receiving the medication on a temporary basis because the client is not able to receive the medication at the program in which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and must not be for the convenience or benefit of either program. Guest dosing may also occur when the client's primary clinic is not open and the client is not receiving take-home doses.

Subd. 9. **Data and reporting.** The license holder must submit data concerning medication used for the treatment of opioid addiction to a central registry. The data must be submitted in a method determined by the commissioner and must be submitted for each client at the time of admission and discharge. The program must document the date the information was submitted. This requirement is effective upon implementation of changes to the Drug and Alcohol Abuse Normative Evaluation System (DAANES) or development of an electronic system by which to submit the data.

Subd. 10. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in Minnesota Rules, part 9530.6430, subpart 1, item A, subitem (1), per week, for the first ten weeks following admission, 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 Minnesota Rules, part 9530.6422, the assessment must be completed within 21 days of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in Minnesota Rules, part 9530.6425:

(1) treatment plan contents for maintenance clients are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for clients in a taper or detox status must include goals the client must reach to complete treatment and have services terminated;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes must be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress no less than one time monthly, recorded in the six dimensions or when clinical need warrants more frequent notations; 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 has needs that warrant more frequent revisions or documentation.

Subd. 11. **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 for each client. The policy and procedure must include how the program will meet the requirements in paragraph (b).

(b) If a medication used for the treatment of opioid addiction is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient treatment program, clients must be notified in writing that the commissioner of human services and the medical director will monitor the prescription monitoring program to review the prescribed controlled drugs the clients have received;

(2) the medical director or the medical director's delegate must review the data from the Minnesota Board of Pharmacy prescription monitoring program (PMP) established under section 152.126 prior to the client being ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and 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 file;

(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 individual file within 72 hours and must contain the medical director'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. In addition, the provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the medical director 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 consent for the other prescriber to disclose to the opioid treatment program's medical director 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 take-home 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 through which the commissioner shall routinely access the data from the Minnesota Board of Pharmacy prescription monitoring program established under section 152.126 for the purpose of determining whether any client enrolled in an opioid addiction treatment program licensed according to this section has also been 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, 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), prior to implementing this subdivision.

Subd. 12. **Policies and procedures.** (a) License holders must develop and maintain the policies and procedures required in this subdivision.

(b) For programs that are not open every day of the year, the license holder must maintain a policy and procedure that permits clients to receive a single unsupervised use of medication used for the treatment of opioid addiction for days that the program is closed for business, including, but not limited to, Sundays and state and federal holidays as required under subdivision 5, paragraph (a), clause (1).

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of medication used for the treatment of opioid addiction being diverted from its intended treatment use. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for carrying out diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication used for the treatment of opioid addiction, excluding those approved solely under subdivision 5, paragraph (a), clause (1), to require them 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 addiction treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the individual client's record.

(d) Medications used for the treatment of opioid addictions must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. In addition, when an 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 such assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor for compliance with these 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.

Subd. 13. **Quality improvement plan.** The license holder must develop and maintain a quality improvement process and plan. The plan must:

(1) include evaluation of the services provided to clients with the goal of identifying issues that may improve service delivery and client outcomes;

(2) include goals for the program to accomplish based on the evaluation;

(3) be reviewed annually by the management of the program to determine whether the goals were met and, if not, whether additional action is required;

(4) be updated at least annually to include new or continued goals based on an updated evaluation of services; and

(5) identify two specific goal areas, in addition to others identified by the program, including:

(i) a goal concerning oversight and monitoring of the premises around and near the exterior of the program to reduce the possibility of medication used for the treatment of opioid addiction being inappropriately used by clients, including but not limited to the sale or transfer of the medication to others; and

(ii) a goal concerning community outreach, including but not limited to communications with local law enforcement and county human services agencies, with the goal of increasing coordination of services and identification of areas of concern to be addressed in the plan.

Subd. 14. **Placing authorities.** Programs must provide certain notification and client-specific updates to placing authorities for clients who are 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 and changes in medications used for the treatment of opioid addiction ordered for the client.

Subd. 15. **A program's duty to report suspected drug diversion.** (a) To the fullest extent permitted under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to law enforcement any credible evidence that the program or its personnel knows, or reasonably should know, that is directly related to a diversion crime on the premises of the program, or a threat to commit a diversion crime.

(b) "Diversion crime," for the purposes of this section, means diverting, attempting to divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02, on the program's premises.

(c) The program must document its compliance with the requirement in paragraph (a) in either a client's record or an incident report.

(d) Failure to comply with the duty in paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

Subd. 16. **Variance.** The commissioner may grant a variance to the requirements of this section.

254A.02 DEFINITIONS.

Subd. 4. **Drug abuse or abuse of drugs.** "Drug abuse or abuse of drugs" is the use of any psychoactive or mood altering chemical substance, without compelling medical reason, in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or

socially disordering behavior and which results in psychological or physiological dependency as a function of continued use.

256B.19 DIVISION OF COST.

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to a demonstration provider serving eligible individuals in Hennepin County under section 256B.69 for the prepaid medical assistance program by approximately $6,800,000 to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to $566,000, and the University of Minnesota's payment under paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $566,000.

(e) Notwithstanding paragraph (d), upon federal enactment of an extension to June 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5, for the six-month period from January 1, 2011, to June 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

256B.64 ATTENDANTS TO VENTILATOR-DEPENDENT RECIPIENTS.

A ventilator-dependent recipient of medical assistance who has been receiving the services of a home care nurse or personal care assistant in the recipient's home may continue to have a home care nurse or personal care assistant present upon admission to a hospital licensed under chapter 144. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. The personal care assistant or home care nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. Within 36 hours of the end of the 120-hour transition period,

an assessment may be made by the ventilator-dependent recipient, the attending physician, and the hospital staff caring for the recipient. If the persons making the assessment determine that additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to the end of the 120-hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section. The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

256B.7631 CHEMICAL DEPENDENCY PROVIDER RATE INCREASE.

For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2015, payment rates shall be increased by two percent over the rates in effect on January 1, 2014, for vendors who meet the requirements of section 254B.05.

Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter 312, article 27, section 72; as amended by Laws 2015, chapter 71, article 7, section 58; as amended by Laws 2016, chapter 144, section 1

Sec. 72. Laws 2012, chapter 247, article 4, section 47, is amended to read:

Sec. 47. **COMMISSIONER TO SEEK AMENDMENT FOR EXCEPTION TO CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY.**

By July 1, 2014, if necessary, the commissioner shall request an amendment to the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to establish an exception to the consumer-directed community supports budget methodology to provide up to 20 percent more funds for those participants who have their 21st birthday and graduate from high school between 2013 to 2015 and are authorized for more services under consumer-directed community supports prior to graduation than the amount they are eligible to receive under the current consumer-directed community supports budget methodology. The exception is limited to those who can demonstrate that they will have to leave consumer-directed community supports and use other waiver services because their need for day or employment supports cannot be met within the consumer-directed community supports budget limits. The commissioner shall consult with the stakeholder group authorized under Minnesota Statutes, section 256B.0657, subdivision 11, to implement this provision. The exception process shall be effective upon federal approval for persons eligible through June 30, 2017.

Laws 2015, chapter 71, article 7, section 54

Sec. 54. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, 2015, 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 establish an exception to the consumer-directed community supports budget methodology to provide up to 20 percent more funds for:

(1) consumer-directed community supports participants who have graduated from high school and have a coordinated service and support plan which identifies the need for more services under consumer-directed community supports, either prior to graduation or in order to increase the amount of time a person works or to improve their employment opportunities, than the amount they are eligible to receive under the current consumer-directed community supports budget methodology; and

(2) home and community-based waiver participants who are currently using licensed services for employment supports or services during the day which cost more annually than the person would spend under a consumer-directed community supports plan for individualized employment supports or services during the day.

(b) The exception under paragraph (a) is limited to those persons who can demonstrate either that they will have to leave consumer-directed community supports and use other waiver services because their need for day or employment supports cannot be met within the consumer-directed community supports budget limits or they will move to consumer-directed community supports and their services will cost less than services currently being used.

EFFECTIVE DATE. The exception under this section is effective October 1, 2015, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when this occurs.

5600.2500 FEES.

The fees charged by the board are fixed at the following rates:

A. physician application fee, $200;

B. physician annual license, $192;

C. physician endorsement to other states, $40;

D. physician emeritus license, $50;

E. physician temporary licenses, $60;

F. physician late fee, $60;

G. physician assistant application fee, $120;

H. physician assistant annual registration (prescribing), $135;

I. physician assistant annual registration (nonprescribing), $115;

J. physician assistant temporary registration, $115;

K. physician assistant temporary permit, $60;

L. physician assistant locum tenens permit, $25;

M. physician assistant late fee, $50;

N. acupuncture temporary permit, $60;

O. acupuncture inactive status fee, $50;

P. respiratory care annual registration, $90;

Q. respiratory care application fee, $100;

R. respiratory care late fee, $50;

S. respiratory care inactive status, $50;

T. respiratory care temporary permit, $60;

U. respiratory care temporary registration, $90;

V. duplicate license or registration fee, $20;

W. certification letter, $25;

X. verification of status, $10;

Y. education or training program approval fee, $100;

Z. report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum; and

AA. examination administrative fee:

(1) half day, $50; and

(2) full day, $80.

The renewal cycle for physician assistants under items H and I begins July 1. The duration of the permit issued under item L is one year.

9500.1140 APPEALS.

Subp. 3. **Case mix appeals.** A hospital may appeal a payment change that results from a difference in case mix between the base year and rate year. The appeal must be received by the commissioner or postmarked no later than 120 days after the end of the appealed rate year. A case mix appeal will apply to all medical assistance patients who received inpatient hospital services from the hospital for which the hospital received medical assistance payment excluding Medicare crossovers and the appeal is effective for the entire rate year. A case mix appeal excludes medical assistance admissions whose payments have been made according to part 9500.1130, subpart 1b, item E. A case mix appeal excludes medical assistance admissions that have a relative value of zero for its DRG. The results of case mix appeals do not automatically carry forward into later rate years. Separate case mix appeals must be submitted for each rate year based on the change in the mix of cases for that particular rate year. An adjustment will be made only to the extent that the need is attributable to circumstances that are separately identified by the hospital. The hospital must demonstrate that the average acuity or length of stay of patients in each rate year appealed has increased or services have been added or discontinued according to items A to J.

A. The change must be measured by use of case mix indices derived using all DRG's. Relative values for each DRG will be determined according to part 9500.1110, subpart 1, by substituting DRG terms and data for diagnostic category terms and data. DRG relative values will be determined based on all programs and the rehabilitation distinct part specialty group. Separate

DRG relative values will be determined for transfers to the neonatal intensive care unit specialty group. For each program and specialty group, make the determinations in subitems (1) to (6).

(1) Multiply the hospital's number of rate year admissions within each DRG by the relative value of that DRG.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the hospital's number of rate year admissions and round the quotient to five decimal places.

(4) Complete the functions in subitems (1) to (3) for the hospital's base year admissions determined in part 9500.1110, subpart 1, item C.

(5) Divide the quotient determined in subitem (3) by the quotient determined in subitem (4).

(6) Multiply subitem (5) by 100 and round the percentage to five decimal places.

B. The percentage change, in whole numbers, between the recalculated case mix indices under item A will be reduced by the change in indices as measured using diagnostic categories in part 9500.1100, subparts 20b to 20g. For each program and specialty group, make the determinations in subitems (1) to (8).

(1) Multiply the hospital's number of rate year admissions within each diagnostic category by the relative value of that diagnostic category as determined in part 9500.1100.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the hospital's number of rate year admissions and round the quotient to five decimal places.

(4) Complete the functions in subitems (1) to (3) for the hospital's base year admissions determined in part 9500.1110, subpart 1, item C.

(5) Divide the quotient determined in subitem (3) by the quotient determined in subitem (4).

(6) Multiply subitem (5) by 100 and round the percentage to five decimal places.

(7) Divide item A, subitem (6), by subitem (6).

(8) Multiply subitem (7) by 100 and round the percentage change to whole numbers.

C. Determine the payments made for admissions occurring during the appealed rate year under part 9500.1128 reduced by property payments made under parts 9500.1121, 9500.1122, 9500.1123, and 9500.1124 for each program and specialty group.

D. Multiply item B, subitem (8), by item C for each program and specialty group.

E. Subtract item C from item D for each program and specialty group.

F. Add the differences in item E.

G. Add the differences in item C.

H. Divide item F by item G. If the quotient is less than positive 0.05 and more than negative 0.05, there can be no payment adjustment for a change in case mix.

I. Subtract 0.05 from the quotient in item H if the quotient is positive or add 0.05 if the quotient is negative.

J. Multiply item G by item I. If the product is positive, there is an underpayment with that amount due the hospital. If the product is negative, there is an overpayment with that amount due the department.

9500.1140 APPEALS.

Subp. 4. **Medicare adjustment appeals.** To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the appeal must be received by the commissioner or postmarked not later than 60 days after the date the medical assistance determination was mailed to the hospital by the department or within 60 days of the date the Medicare determination was mailed to the hospital by Medicare, whichever is later.

9500.1140 APPEALS.

Subp. 5. **Rate and payment appeals.** To appeal a payment rate or payment determination that is not a case mix or Medicare adjustment appeal, the appeal must be received by the commissioner within 60 days of the date the determination was mailed to the hospital.

9500.1140 APPEALS.

Subp. 6. **Resolution of appeals.** The appeal will be heard by an administrative law judge according to parts 1400.5100 to 1400.8401 and Minnesota Statutes, sections 14.57to 14.62, and according to the requirements of items A to D.

A. The hospital must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

B. Both overpayments and underpayments that result from the submission of appeals will be implemented.

C. Facts to be considered in any appeal of base year information are limited to those in existence at the time the payment rates of the first rate year were established from the base year information.

D. Relative values and rates that are based on averages will not be recalculated to reflect the appeal outcome.

9530.6405 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9530.6405 to 9530.6505, the following terms have the meanings given to them.

9530.6405 DEFINITIONS.

Subp. 1a. **Administration of medications.** "Administration of medications" means performing a task to provide medications to a client, and includes the following tasks, performed in the following order:

A. checking the client's medication record;

B. preparing the medication for administration;

C. administering the medication to the client;

D. documenting the administration, or the reason for not administering medications as prescribed; and

E. reporting information to a licensed practitioner or a nurse regarding problems with the administration of the medication or the client's refusal to take the medication.

9530.6405 DEFINITIONS.

Subp. 2. **Adolescent.** "Adolescent" means an individual under 18 years of age.

9530.6405 DEFINITIONS.

Subp. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning given in Minnesota Statutes, section 148C.01, subdivision 2.

9530.6405 DEFINITIONS.

Subp. 4. **Applicant.** "Applicant" means an individual, corporation, partnership, voluntary association, controlling individual, or other organization that has applied for licensure under this chapter.

9530.6405 DEFINITIONS.

Subp. 5. **Capacity management system.** "Capacity management system" means a database operated by the Department of Human Services to compile and make information available to the public about the waiting list status and current admission capability of each program serving intravenous drug abusers.

9530.6405 DEFINITIONS.

Subp. 6. **Central registry.** "Central registry" means a database maintained by the department that collects identifying information from two or more programs about individuals applying for maintenance treatment or detoxification treatment for addiction to opiates for the purpose of avoiding an individual's concurrent enrollment in more than one program.

9530.6405 DEFINITIONS.

Subp. 7. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as defined by Minnesota Statutes, section 152.01, subdivision 4, and other mood altering substances.

9530.6405 DEFINITIONS.

Subp. 7a. **Chemical dependency treatment.** "Chemical dependency treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned interventions or services to address those needs, provision of services, facilitation of services provided by other service providers, and reassessment by a qualified professional. The goal of treatment is to assist or support the client's efforts to recover from substance use disorder.

9530.6405 DEFINITIONS.

Subp. 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 plans to provide the individual with treatment services.

9530.6405 DEFINITIONS.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designee.

9530.6405 DEFINITIONS.

Subp. 10. **Co-occurring or co-occurring client.** "Co-occurring" or "co-occurring client" means a diagnosis that indicates a client suffers from a substance use disorder and a mental health problem.

9530.6405 DEFINITIONS.

Subp. 11. **Department.** "Department" means the Department of Human Services.

9530.6405 DEFINITIONS.

Subp. 12. **Direct client contact.** "Direct client contact" has the meaning given for "direct contact" in Minnesota Statutes, section 245C.02, subdivision 11.

9530.6405 DEFINITIONS.

Subp. 13. **License.** "License" means a certificate issued by the commissioner authorizing the license holder to provide a specific program for a specified period of time in accordance with the terms of the license and the rules of the commissioner.

9530.6405 DEFINITIONS.

Subp. 14. **License holder.** "License holder" means an individual, corporation, partnership, voluntary organization, or other organization that is legally responsible for the operation of the program, has been granted a license by the commissioner under this chapter, and is a controlling individual.

9530.6405 DEFINITIONS.

Subp. 14a. **Licensed practitioner.** "Licensed practitioner" means a person who is authorized to prescribe as defined in Minnesota Statutes, section 151.01, subdivision 23.

9530.6405 DEFINITIONS.

Subp. 15. **Licensed professional in private practice.** "Licensed professional in private practice" means an individual who meets the following criteria:

A. is licensed under Minnesota Statutes, chapter 148C, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

B. practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

C. does not affiliate with other licensed or unlicensed professionals for the purpose of providing alcohol and drug counseling services. Affiliation does not include conferring with other professionals or making client referrals.

9530.6405 DEFINITIONS.

Subp. 15a. **Nurse.** "Nurse" means a person licensed and currently registered to practice professional or practical nursing as defined in Minnesota Statutes, section 148.171, subdivisions 14 and 15.

9530.6405 DEFINITIONS.

Subp. 16. **Paraprofessional.** "Paraprofessional" means an employee, agent, or independent contractor of the license holder who performs tasks in support of the provision of treatment services. Paraprofessionals may be referred to by a variety of titles including technician, case aide, or counselor assistant. An individual may not be a paraprofessional employed by the license holder if the individual is a client of the license holder.

9530.6405 DEFINITIONS.

Subp. 17. **Program serving intravenous drug abusers.** "Program serving intravenous drug abusers" means a program whose primary purpose is providing agonist medication-assisted therapy to clients who are narcotic dependent, regardless of whether the client's narcotic use was intravenous or by other means.

9530.6405 DEFINITIONS.

Subp. 17a. **Student intern.** "Student intern" means a person who is enrolled in an alcohol and drug counselor education program at an accredited school or educational program and is earning a minimum of nine semester credits per calendar year toward the completion of an associate's, bachelor's, master's, or doctorate degree requirements. Degree requirements must include an additional 18 semester credits or 270 hours of alcohol and drug counseling related course work and 440 hours of practicum.

9530.6405 DEFINITIONS.

Subp. 17b. **Substance.** "Substance" means a "chemical" as defined in subpart 7.

9530.6405 DEFINITIONS.

Subp. 17c. **Substance use disorder.** "Substance use disorder" means a pattern of substance use as defined in the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM), et seq. The DSM-IV-TR is incorporated by reference. The DSM was published by the American Psychiatric Association in 1994, in Washington D.C., and is not subject to frequent change. The DSM-IV-TR is available through the Minitex interlibrary loan system.

9530.6405 DEFINITIONS.

Subp. 18. **Target population.** "Target population" means individuals experiencing problems with a substance use disorder having the specified characteristics that a license holder proposes to serve.

9530.6405 DEFINITIONS.

Subp. 20. **Treatment director.** "Treatment director" means an individual who meets the qualifications specified under part 9530.6450, subparts 1 and 3, and is designated by the license holder to be responsible for all aspects of the delivery of treatment services.

9530.6405 DEFINITIONS.

Subp. 21. **Treatment service.** "Treatment service" means a therapeutic intervention or series of interventions.

9530.6410 APPLICABILITY.

Subpart 1. **Applicability.** Except as provided in subparts 2 and 3, no person, corporation, partnership, voluntary association, controlling individual, or other organization may provide chemical dependency treatment services to an individual who has a substance use disorder unless licensed by the commissioner.

Subp. 2. **Activities exempt from license requirement.** Parts 9530.6405 to 9530.6505 do not apply to organizations whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of placement, education, support group services, or self-help programs. Parts 9530.6405 to 9530.6505do not apply to the activities of licensed professionals in private practice which are not paid for by the consolidated chemical dependency treatment fund.

Subp. 3. **Certain hospitals excluded from license requirement.** Parts 9530.6405 to 9530.6505 do not apply to chemical dependency treatment provided by hospitals licensed

under Minnesota Statutes, chapter 62J, or under Minnesota Statutes, sections 144.50 to 144.56, unless the hospital accepts funds for chemical dependency treatment under the consolidated chemical dependency treatment fund under Minnesota Statutes, chapter 254B, medical assistance under Minnesota Statutes, chapter 256B, MinnesotaCare or health care cost containment under Minnesota Statutes, chapter 256L, or general assistance medical care under Minnesota Statutes, chapter 256D.

Subp. 4. **Applicability of chapter 2960.** Beginning July 1, 2005, residential adolescent chemical dependency treatment programs must be licensed according to chapter 2960.

9530.6415 LICENSING REQUIREMENTS.

Subpart 1. **General application and license requirements.** An applicant for a license to provide treatment must comply with the general requirements in Minnesota Statutes, chapters 245A and 245C, and Minnesota Statutes, sections 626.556 and 626.557.

Subp. 2. **Contents of application.** Prior to issuance of a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires to demonstrate the following:

A. compliance with parts 9530.6405 to 9530.6505;

B. compliance with applicable building, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or documentation that a waiver has been granted. The granting of a waiver does not constitute modification of any requirement of parts 9530.6405 to 9530.6505;

C. completion of an assessment of need for a new or expanded program according to part 9530.6800; and

D. insurance coverage, including bonding, sufficient to cover all client funds, property, and interests.

Subp. 3. **Changes in license terms.**

A. A license holder must notify the commissioner before one of the following occurs and the commissioner must determine the need for a new license:

(1) a change in the Department of Health's licensure of the program;

(2) a change in whether the license holder provides services specified in parts 9530.6485 to 9530.6505;

(3) a change in location; or

(4) a change in capacity if the license holder meets the requirements of part 9530.6505.

B. A license holder must notify the commissioner and must apply for a new license if there is a change in program ownership.

9530.6420 INITIAL SERVICES PLAN.

The license holder must complete an initial services plan during or immediately following the intake interview. The plan must address the client's immediate health and safety concerns, identify the issues to be addressed in the first treatment sessions, and make treatment suggestions for the client during the time between intake and completion of the treatment plan. The initial services plan must include a determination whether a client is a vulnerable adult as defined in Minnesota Statutes, section 626.5572, subdivision 21. All adult clients of a residential program are vulnerable adults. An individual abuse prevention plan, according to Minnesota Statutes, sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph (b), is required for all clients who meet the definition of "vulnerable adult."

9530.6422 COMPREHENSIVE ASSESSMENT.

Subpart 1. **Comprehensive assessment of substance use disorder.** A comprehensive assessment of the client's substance use disorder must be coordinated by an alcohol and drug counselor and completed within three calendar days after service initiation for a residential program or three sessions of the client's initiation to services for all other programs. The alcohol and drug counselor may rely on current information provided by a referring agency or other sources as a supplement when information is available. Information gathered more than 45 days before the date of admission is not current. If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate how and when it will be completed. The assessment must include sufficient information to complete the assessment summary according to subpart 2 and part 9530.6425. The comprehensive assessment must include information about

the client's problems that relate to chemical use and personal strengths that support recovery, including:

A. age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;

B. circumstances of service initiation;

C. previous attempts at treatment for chemical use or dependency, compulsive gambling, or mental illness;

D. chemical use history including amounts and types of chemicals used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each chemical used within the previous 30 days, the information must include the date and time of the most recent use and any previous experience with withdrawal;

E. specific problem behaviors exhibited by the client when under the influence of chemicals;

F. current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse, or dependency among family members and significant others;

G. physical concerns or diagnoses, the severity of the concerns, and whether or not the concerns are being addressed by a health care professional;

H. mental health history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability;

I. arrests and legal interventions related to chemical use;

J. ability to function appropriately in work and educational settings;

K. ability to understand written treatment materials, including rules and client rights;

L. risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases;

M. social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use;

N. whether the client is pregnant and if so, the health of the unborn child and current involvement in prenatal care; and

O. whether the client recognizes problems related to substance use and is willing to follow treatment recommendations.

Subp. 2. **Assessment summary.** An alcohol and drug counselor must prepare an assessment summary within three calendar days for a residential program or within three treatment sessions of service initiation. The narrative summary of the comprehensive assessment results must meet the requirements of items A and B:

A. An assessment summary must be prepared by an alcohol and drug counselor and include:

(1) a risk description according to part 9530.6622 for each dimension listed in item B;

(2) narrative supporting the risk descriptions; and

(3) a determination of whether the client meets the DSM criteria for a person with a substance use disorder.

B. Contain information relevant to treatment planning and recorded in the dimensions in subitems (1) to (6):

(1) Dimension 1, acute intoxication/withdrawal potential. The license holder must consider the client's ability to cope with withdrawal symptoms and current state of intoxication.

(2) Dimension 2, biomedical conditions and complications. The license holder must consider the degree to which any physical disorder would interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child if the client is pregnant.

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications. The license holder must determine the degree to which any condition or complications are likely to interfere with treatment for substance abuse or with functioning in significant life areas and the likelihood of risk of harm to self or others.

(4) Dimension 4, readiness for change. The license holder must also consider the amount of support and encouragement necessary to keep the client involved in treatment.

(5) Dimension 5, relapse, continued use, and continued problem potential. The license holder must consider the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

(6) Dimension 6, recovery environment. The license holder must consider the degree to which key areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

9530.6425 INDIVIDUAL TREATMENT PLANS.

Subpart 1. **General.** Individual treatment plans for clients in treatment must be completed within seven calendar days of completion of the assessment summary. Treatment plans must continually be updated, based on new information gathered about the client's condition and on whether planned treatment interventions have had the intended effect. Treatment planning must include ongoing assessment in each of the six dimensions according to part 9530.6422, subpart 2. The plan must provide for the involvement of the client's family and those people selected by the client as being important to the success of the treatment experience at the earliest opportunity, consistent with the client's treatment needs and written consent. The plan must be developed after completion of the comprehensive assessment and is subject to amendment until services to the client are terminated. The client must have an opportunity to have active, direct involvement in selecting the anticipated outcomes of the treatment process and in developing the individual treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor. The individual treatment plan may be a continuation of the initial services plan required in part 9530.6420.

Subp. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and address each problem identified in the assessment summary, and include:

A. specific methods to be used to address identified problems, 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;

B. resources to which the client is being referred for problems when problems are to be addressed concurrently by another provider; and

C. goals the client must reach to complete treatment and have services terminated.

Subp. 3. **Progress notes and plan review.**

A. Progress notes must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff person providing the service. The note must reference the treatment plan. Progress notes must be recorded and address each of the six dimensions listed in part 9530.6422, subpart 2, item B. Progress notes must:

(1) be entered immediately following any significant event. Significant events include those events which have an impact on the client's relationship with other clients, staff, the client's family, or the client's treatment plan;

(2) indicate the type and amount of each treatment service the client has received;

(3) include monitoring of any physical and mental health problems and the participation of others in the treatment plan;

(4) document the participation of others; and

(5) document that the client has been notified of each treatment plan change and that the client either does or does not agree with the change.

B. Treatment plan review must:

(1) occur weekly or after each treatment service, whichever is less frequent;

(2) address each goal in the treatment plan that has been worked on since the last review;

(3) address whether the strategies to address the goals are effective, and if not, must include changes to the treatment plan; and

(4) include a review and evaluation of the individual abuse prevention plan according to Minnesota Statutes, section 245A.65.

C. All entries in a client's record must be legible, signed, and dated. Late entries must be clearly labeled "late entry." Corrections to an entry must be made in a way in which the original entry can still be read.

Subp. 3a. **Documentation.** Progress notes and plan review do not require separate documentation if the information in the client file meets the requirements of subpart 3, items A and B.

Subp. 4. **Summary at termination of services.** An alcohol and drug counselor must write a discharge summary for each client. The 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. The summary at termination of services must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and include the following information:

(1) client's problems, strengths, and needs while participating in treatment, including services provided;

(2) client's progress toward achieving each of the goals identified in the individual treatment plan;

(3) reasons for and circumstances of service termination; and

(4) risk description according to part 9530.6622.

B. For clients who successfully complete treatment, the summary must also include:

(1) living arrangements upon discharge;

(2) continuing care recommendations, including referrals made with specific attention to continuity of care for mental health problems, as needed;

(3) service termination diagnosis; and

(4) client's prognosis.

9530.6430 TREATMENT SERVICES.

Subpart 1. **Treatment services offered by license holder.**

A. A license holder must offer the following treatment services unless clinically inappropriate and the justifying clinical rationale is documented:

(1) individual and group counseling to help the client identify and address problems related to chemical use and develop strategies to avoid inappropriate chemical use after discharge;

(2) client education strategies to avoid inappropriate chemical use and health problems related to chemical use and the necessary changes in lifestyle to regain and maintain health. Client education must include information concerning the human immunodeficiency virus, according to Minnesota Statutes, section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, hepatitis, and tuberculosis;

(3) transition services to help the client integrate gains made during treatment into daily living and to reduce reliance on the license holder's staff for support;

(4) services to address issues related to co-occurring mental illness, including education for clients on basic symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while working on recovery from substance use disorder. Groups must address co-occurring mental illness issues, as needed. When treatment for mental health problems is indicated, it is integrated into the client's treatment plan; and

(5) service coordination to help the client obtain the services and to support the client's need to establish a lifestyle free of the harmful effects of substance use disorder.

B. Treatment services provided to individual clients must be provided according to the individual treatment plan and must address cultural differences and special needs of all clients.

Subp. 2. **Additional treatment services.** A license holder may provide or arrange the following additional treatment services as a part of the individual treatment plan:

A. 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;

B. therapeutic recreation to provide the client with an opportunity to participate in recreational activities without the use of mood-altering chemicals and to learn to plan and select leisure activities that do not involve the inappropriate use of chemicals;

C. stress management and physical well-being to help the client reach and maintain an acceptable level of health, physical fitness, and well-being;

D. living skills development to help the client learn basic skills necessary for independent living;

E. employment or educational services to help the client become financially independent;

F. socialization skills development to help the client live and interact with others in a positive and productive manner; and

G. room, board, and supervision provided at the treatment site to give the client a safe and appropriate environment in which to gain and practice new skills.

Subp. 3. **Counselors to provide treatment services.** Treatment services, including therapeutic recreation, must be provided by alcohol and drug counselors qualified according to part 9530.6450, unless the individual providing the service is specifically qualified according to the accepted standards of that profession. Therapeutic recreation does not include planned leisure activities.

Subp. 4. **Location of service provision.** A client of a license holder may only receive services at any of the license holder's licensed locations or at the client's home, except that services under subpart 1, item A, subitems (3) and (5), and subpart 2, items B and E, may be provided in another suitable location.

9530.6435 MEDICAL SERVICES.

Subpart 1. **Health care services description.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the license holder.

Subp. 1a. **Procedures.** The applicant or license holder must have written procedures for obtaining medical interventions when needed for a client, that are approved in writing by a physician who is licensed under Minnesota Statutes, chapter 147, unless:

A. the license holder does not provide services under part 9530.6505; and

B. all medical interventions are referred to 911, the emergency telephone number, or the client's physician.

Subp. 2. **Consultation services.** The license holder must have access to and document the availability of a licensed mental health professional to provide diagnostic assessment and treatment planning assistance.

Subp. 3. **Administration of medications and assistance with self-medication.** A license holder must meet the requirements in items A and B if services include medication administration.

A. A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assistance with self-medication must:

(1) document that the staff member has successfully completed a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. Completion of the course must be documented in writing and placed in the staff member's personnel file; or

(2) be trained according to a formalized training program which is taught by a registered nurse and offered by the license holder. Completion of the course must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity.

B. A registered nurse must be employed or contracted to develop the policies and procedures for medication administration or assistance with self-administration of medication or both. A registered nurse must provide supervision as defined in part 6321.0100. The registered nurse supervision must include monthly on-site supervision or more often as warranted by client health needs. The policies and procedures must include:

(1) a provision that delegations of administration of medication are limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical;

(2) a provision that each client's file must include documentation indicating whether staff will be administering medication or the client will be doing self-administration or a combination of both;

(3) a provision that clients may carry emergency medication such as nitroglycerin as instructed by their physician;

(4) a provision for medication to be self-administered when a client is scheduled not to be at the facility;

(5) a provision that if medication is to be self-administered at a time when the client is present in the facility, medication will be self-administered under observation of a trained staff person;

(6) a provision that when a license holder serves clients who are parents with children, the parent may only administer medication to the child under staff supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a registered nurse of problems with self-administration, including failure to administer, client refusal of a medication, adverse reactions, or errors; and

(9) procedures for acceptance, documentation, and implementation of prescriptions, whether written, verbal, telephonic, or electronic.

Subp. 4. **Control of drugs.** A license holder must have in place and implement written policies and procedures developed by a registered nurse that contains the following provisions:

A. a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

B. a system which accounts for all scheduled drugs each shift;

C. a procedure for recording the client's use of medication, including the signature of the administrator of the medication with the time and date;

D. a procedure for destruction of discontinued, outdated, or deteriorated medications;

E. a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and

F. a statement that no legend drug supply for one client will be given to another client.

9530.6440 CLIENT RECORDS.

Subpart 1. **Client records required.** A license holder must maintain a file of current client records on the premises where the treatment services are provided or coordinated. The content and format of client records must be uniform and entries in each case must be signed and dated by the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure in compliance with Minnesota Statutes, section 254A.09, Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164, and, if applicable, Minnesota Statutes, chapter 13.

Subp. 2. **Records retention.** Records of discharged clients must be retained by a license holder for seven years. License holders that cease to provide treatment services must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the records and the name of a person responsible for maintaining the records.

Subp. 3. **Client records, contents.** Client records must contain the following:

A. documentation that the client was given information on client rights, responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan as required under Minnesota Statutes, section 245A.65, subdivision 2, paragraph (a), clause (4);

B. an initial services plan completed according to part 9530.6420;

C. a comprehensive assessment completed according to part 9530.6422;

D. an assessment summary completed according to part 9530.6422, subpart 2;

E. an individual abuse prevention plan that complies with Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

F. an individual treatment plan, as required under part 9530.6425, subparts 1 and 2;

G. progress notes, as required in part 9530.6425, subpart 3; and

H. a summary of termination of services, written according to part 9530.6425, subpart 4.

Subp. 4. **Electronic records.** A license holder who intends to use electronic record keeping or electronic signatures to comply with parts 9530.6405 to 9530.6505 must first obtain written permission from the commissioner. The commissioner must grant permission after the license holder provides documentation demonstrating the license holder's use of a system for ensuring security of electronic records. Use of electronic record keeping or electronic signatures does not alter the license holder's obligations under state or federal law, regulation, or rule.

9530.6445 STAFFING REQUIREMENTS.

Subpart 1. **Treatment director required.** A license holder must have a treatment director.

Subp. 2. **Alcohol and drug counselor supervisor requirements.** A license holder must employ an alcohol and drug counselor supervisor who meets the requirements under part 9530.6450, subpart 4. An individual may be simultaneously employed as a treatment director, alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual meets the qualifications for each position. If an alcohol and drug counselor is simultaneously an alcohol and drug counselor supervisor or treatment director, that individual must be considered a 0.5 full-time equivalent alcohol and drug counselor for purposes of meeting the staffing requirements under subpart 4.

Subp. 3. **Responsible staff person.** A treatment director must designate a staff member who, when present in the facility, is responsible for the delivery of treatment services. A license holder must have a designated staff person during all hours of operation. A license holder providing room and board and treatment at the same site must have a responsible staff person on duty 24 hours a day. The designated staff person must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 4. **Staffing requirements.** 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 shall not exceed an average of 16 clients during any 30 consecutive calendar days. It is the responsibility of the license holder to determine an acceptable group size based on the client's needs. A counselor in a program treating intravenous drug abusers must not supervise more than 50 clients. The license holder must maintain a record that documents compliance with this subpart.

Subp. 5. **Medical emergencies.** When clients are present, a license holder must have at least one staff person on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at least one staff person on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff person with both certifications satisfies this requirement.

9530.6450 STAFF QUALIFICATIONS.

Subpart 1. **Qualifications of all staff members with direct client contact.** All staff members who have direct client contact must be at least 18 years of age. At the time of hiring, all staff members must meet the qualifications in item A or B. A chemical use problem for purposes of this subpart is a problem listed by the license holder in the personnel policies and procedures according to part 9530.6460, subpart 1, item E.

A. Treatment directors, supervisors, nurses, counselors, and other professionals must be free of chemical use problems for at least the two years immediately preceding their hiring and must sign a statement attesting to that fact.

B. Paraprofessionals and all other staff members with direct client contact must be free of chemical use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.

Subp. 2. **Employment; prohibition on chemical use problems.** Staff members with direct client contact must be free from chemical use problems as a condition of employment, but are not required to sign additional statements. Staff members with direct client contact who are not free from chemical use problems must be removed from any responsibilities that include direct client contact for the time period specified in subpart 1. The time period begins to run on the date the employee begins receiving treatment services or the date of the last incident as described in the list developed according to part 9530.6460, subpart 1, item E.

Subp. 3. **Treatment director qualifications.** In addition to meeting the requirements of subpart 1, a treatment director must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, chapter 245A, and sections 626.556, 626.557, and 626.5572. A treatment director must:

A. have at least one year of work experience in direct service to individuals with chemical use problems or one year of work experience in the management or administration of direct service to individuals with chemical use problems; and

B. have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services.

Subp. 4. **Alcohol and drug counselor supervisor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor supervisor must meet the following qualifications:

A. the individual is competent in the areas specified in subpart 5;

B. the individual has three or more years of experience providing individual and group counseling to chemically dependent clients except that, prior to January 1, 2005, an individual employed in a program formerly licensed under parts 9530.5000 to 9530.6400is required to have one or more years experience; and

C. the individual knows and understands the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 5. **Alcohol and drug counselor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor must be either licensed or exempt from licensure under Minnesota Statutes, chapter 148C. An alcohol and drug counselor must document competence in screening for and working with clients with mental health problems, through education, training, and experience.

A. Alcohol and drug counselors licensed under Minnesota Statutes, chapter 148C, must comply with rules adopted under Minnesota Statutes, chapter 148C.

B. Counselors exempt under Minnesota Statutes, chapter 148C, must be competent, as evidenced by one of the following:

(1) completion of at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, or licensure as a registered nurse; successful completion of a minimum of 120 hours of classroom instruction in which each of the core functions listed in Minnesota Statutes, chapter 148C, is covered; and successful completion of 440 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member;

(2) completion of 270 hours of alcohol and drug counselor training in which each of the core functions listed in Minnesota Statutes, chapter 148C, is covered, and successful completion of 880 hours of supervised experience as an alcohol and drug counselor, either as a student, or as a staff member;

(3) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1993. The manual is incorporated by reference. It is available at the State Law Library, Judicial Center, 25 Reverend Dr. Martin Luther King Jr. Blvd., St. Paul, Minnesota 55155;

(4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling education from an accredited school or educational program and 880 hours of alcohol and drug counseling practicum; or

(5) employment in a program formerly licensed under parts 9530.5000 to 9530.6400 and successful completion of 6,000 hours of supervised work experience in a licensed program as an alcohol and drug counselor prior to January 1, 2005.

Subp. 6. **Paraprofessional qualifications and duties.** A paraprofessional must comply with subpart 1 and have knowledge of client rights, outlined in Minnesota Statutes, section 148F.165, and of staff responsibilities. A paraprofessional may not admit, transfer, or discharge clients but may be the person responsible for the delivery of treatment services as required in part 9530.6445, subpart 3.

Subp. 7. **Volunteers.** Volunteers may provide treatment services when they are supervised and can be seen or heard by a staff member meeting the criteria in subpart 4 or 5, but may not practice alcohol and drug counseling unless qualified under subpart 5.

Subp. 8. **Student interns.** A qualified staff person must supervise and be responsible for all treatment services performed by student interns and must review and sign all assessments, progress notes, and treatment plans prepared by the intern. Student interns must meet the requirements in subpart 1, item A, and receive the orientation and training required in part 9530.6460, subpart 1, item G, and subpart 2.

Subp. 9. **Individuals with temporary permit.** Individuals with a temporary permit from the Board of Behavioral Health and Therapy may provide chemical dependency treatment services under the conditions in either item A or B.

A. The individual is supervised by a licensed alcohol and drug counselor assigned by the license holder. The licensed alcohol and drug counselor must document the amount and type of supervision at least weekly. The supervision must relate to clinical practices. One licensed alcohol and drug counselor may not supervise more than three individuals with temporary permits, according to Minnesota Statutes, section 148C.01, subdivision 12a.

B. The individual is supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of Minnesota Statutes, section 148C.044, subdivision 4.

9530.6455 PROVIDER POLICIES AND PROCEDURES.

License holders must develop a written policy and procedures manual indexed according to Minnesota Statutes, section 245A.04, subdivision 14, paragraph (c), so that staff may have immediate access to all policies and procedures and so that consumers of the services and other authorized parties may have access to all policies and procedures. The manual must contain the following materials:

A. assessment and treatment planning policies, which include screening for mental health concerns, and the inclusion of treatment objectives related to identified mental health concerns in the client's treatment plan;

B. policies and procedures regarding HIV that comply with Minnesota Statutes, section 245A.19;

C. the methods and resources used by the license holder to provide information on tuberculosis and tuberculosis screening to all clients and to report known cases of tuberculosis infection according to Minnesota Statutes, section 144.4804;

D. personnel policies that comply with part 9530.6460;

E. policies and procedures that protect client rights as required under part 9530.6470;

F. a medical services plan that complies with part 9530.6435;

G. emergency procedures that comply with part 9530.6475;

H. policies and procedures for maintaining client records under part 9530.6440;

I. procedures for reporting the maltreatment of minors under Minnesota Statutes, section 626.556, and vulnerable adults under Minnesota Statutes, sections 245A.65, 626.557, and 626.5572;

J. a description of treatment services including the amount and type of client services provided;

K. the methods used to achieve desired client outcomes; and

L. the hours of operation and target population served.

9530.6460 PERSONNEL POLICIES AND PROCEDURES.

Subpart 1. **Policy requirements.** License holders must have written personnel policies and must make them available to each staff member. The policies must:

A. assure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the Department of Health, the Department of Human Services, the ombudsman for mental health and developmental disabilities, law enforcement, or local agencies for the investigation of complaints regarding a client's rights, health, or safety;

B. contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, and qualifications;

C. provide for job performance evaluations based on standards of job performance to be conducted on a regular and continuing basis, including a written annual review;

D. describe behavior that constitutes grounds for disciplinary action, suspension or dismissal, including policies that address chemical use problems and meet the requirements of part 9530.6450, subpart 1, policies prohibiting personal involvement with clients in violation of Minnesota Statutes, chapter 604, and policies prohibiting client abuse as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572;

E. list behaviors or incidents that are considered chemical use problems. The list must include:

(1) receiving treatment for chemical use within the period specified for the position in the staff qualification requirements;

(2) chemical use that has a negative impact on the staff member's job performance;

(3) chemical use that affects the credibility of treatment services with clients, referral sources, or other members of the community; and

(4) symptoms of intoxication or withdrawal on the job;

F. include a chart or description of the organizational structure indicating lines of authority and responsibilities;

G. include orientation within 24 working hours of starting for all new staff based on a written plan that, at a minimum, must provide for training related to the specific job functions for which the staff member was hired, policies and procedures, client confidentiality, the human immunodeficiency virus minimum standards, and client needs; and

H. policies outlining the license holder's response to staff members with behavior problems that interfere with the provision of treatment services.

Subp. 2. **Staff development.** A license holder must ensure that each staff person has the training required in items A to E.

A. All staff must be trained every two years in client confidentiality rules and regulations and client ethical boundaries.

B. All staff must be trained every two years in emergency procedures and client rights as specified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03.

C. All staff with direct client contact must be trained every year on mandatory reporting as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.5561, 626.5563, 626.557, and 626.5572, including specific training covering the facility's policies concerning obtaining client releases of information.

D. All staff with direct client contact must receive training upon hiring and annually thereafter on the human immunodeficiency virus minimum standards according to Minnesota Statutes, section 245A.19.

E. Treatment directors, supervisors, nurses, and counselors must obtain 12 hours of training in co-occurring mental health problems and substance use disorder that includes competencies related to philosophy, screening, assessment, diagnosis and treatment planning, documentation, programming, medication, collaboration, mental health consultation, and discharge planning. Staff employed by a license holder on the date this rule is adopted must obtain the training within 12 months of the date of adoption. New staff who have not obtained such training must obtain it within 12 months of the date this rule is adopted or within six months of hire, whichever is later. Staff may request, and the license holder may grant credit for, relevant training obtained prior to January 1, 2005.

Subp. 3. **Personnel files.** The license holder must maintain a separate personnel file for each staff member. At a minimum, the personnel file must be maintained to meet the requirements under parts 9530.6405 to 9530.6505 and contain the following:

A. a completed application for employment signed by the staff member and containing the staff member's qualifications for employment;

B. documentation related to the applicant's background study data, as defined in Minnesota Statutes, chapter 245C;

C. for staff members who will be providing psychotherapy services, employer names and addresses for the past five years for which the staff member provided psychotherapy services, and documentation of an inquiry made to these former employers regarding substantiated sexual contact with a client as required by Minnesota Statutes, chapter 604;

D. documentation of completed orientation and training;

E. documentation demonstrating compliance with parts 9530.6450 and 9530.6485, subpart 2; and

F. documentation demonstrating compliance with part 9530.6435, subpart 3, for staff members who administer medications.

9530.6465 SERVICE INITIATION AND TERMINATION POLICIES.

Subpart 1. **Service initiation policy.** A license holder must have a written service initiation policy containing service initiation preferences which comply with this rule and Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria. The license holder must not initiate services for individuals who do not meet the service initiation criteria. The service initiation criteria must be either posted in the area of the facility where services for clients are initiated, or given to all interested persons upon request. Titles of all staff members authorized

to initiate services for clients must be listed in the services initiation and termination policies. A license holder that serves intravenous drug abusers must have a written policy that provides service initiation preference as required by Code of Federal Regulations, title 45, part 96.131.

Subp. 2. **License holder responsibilities; terminating or denying services.** A license holder has specific responsibilities when terminating services or denying treatment service initiation to clients for reasons of health, behavior, or criminal activity.

A. The license holder must have and comply with a written protocol for assisting clients in need of care not provided by the license holder, and for clients who pose a substantial likelihood of harm to themselves or others, if the behavior is beyond the behavior management capabilities of the staff. All service terminations and denials of service initiation which pose an immediate threat to the health of any individual or require immediate medical intervention must be referred to a medical facility capable of admitting the individual.

B. All service termination policies and denials of service initiation that involve the commission of a crime against a license holder's staff member or on a license holder's property, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and Code of Federal Regulations, title 45, parts 160 to 164, must be reported to a law enforcement agency with proper jurisdiction.

Subp. 3. **Service termination and transfer policies.** A license holder must have a written policy specifying the conditions under which clients must be discharged. The policy must include:

A. procedures for individuals whose services have been terminated under subpart 2;

B. a description of client behavior that constitutes reason for a staff-requested service termination and a process for providing this information to clients;

C. procedures consistent with Minnesota Statutes, section 253B.16, subdivision 2, that staff must follow when a client admitted under Minnesota Statutes, chapter 253B, is to have services terminated;

D. procedures staff must follow when a client leaves against staff or medical advice and when the client may be dangerous to self or others;

E. procedures for communicating staff-approved service termination criteria to clients, including the expectations in the client's individual treatment plan according to part 9530.6425; and

F. titles of staff members authorized to terminate client services must be listed in the service initiation and termination policies.

9530.6470 POLICIES AND PROCEDURES THAT PROTECT CLIENT RIGHTS.

Subpart 1. **Client rights; explanation.** Clients have the rights identified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03, as applicable. The license holder must give each client upon service initiation a written statement of client's rights and responsibilities. Staff must review the statement with clients at that time.

Subp. 2. **Grievance procedure.** Upon service initiation, the license holder must explain the grievance procedure to the client or their representative. The grievance procedure must be posted in a place visible to clients, and made available upon a client's request. The grievance procedure must also be made available to former clients upon request. The grievance procedure must require that:

A. staff help the client develop and process a grievance;

B. telephone numbers and addresses of the Department of Human Services, licensing division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Minnesota Department of Health, Office of Alcohol and Drug Counselor Licensing Program, and Office of Health Facilities Complaints; when applicable, be made available to clients; and

C. a license holder be obligated to respond to the client's grievance within three days of a staff member's receipt of the grievance, and the client be permitted to bring the grievance to the highest level of authority in the program if not resolved by other staff members.

Subp. 3. **Photographs of client.** All photographs, video tapes, and motion pictures of clients taken in the provision of treatment services are considered client records. Photographs for identification and recordings by video and audio tape for the purpose of enhancing either therapy or staff supervision may be required of clients, but may only be available for use as communications within a program. Clients must be informed when their actions are being recorded by camera or tape, and have the right to deny any taping or photography, except as authorized by this subpart.

9530.6475 BEHAVIORAL EMERGENCY PROCEDURES.

A. A license holder or applicant must have written procedures that staff must follow when responding to a client who exhibits behavior that is threatening to the safety of the client or others. The procedures must include:

(1) a plan designed to prevent the client from hurting themselves or others;

(2) contact information for emergency resources that staff must consult when a client's behavior cannot be controlled by the procedures established in the plan;

(3) types of procedures that may be used;

(4) circumstances under which emergency procedures may be used; and

(5) staff members authorized to implement emergency procedures.

B. Behavioral emergency procedures must not be used to enforce facility rules or for the convenience of staff. Behavioral emergency procedures must not be part of any client's treatment plan, or used at any time for any reason except in response to specific current behaviors that threaten the safety of the client or others. Behavioral emergency procedures may not include the use of seclusion or restraint.

9530.6480 EVALUATION.

Subpart 1. **Participation in drug and alcohol abuse normative evaluation system.** License holders must participate in the drug and alcohol abuse normative evaluation system by submitting information about each client to the commissioner in a format specified by the commissioner.

Subp. 2. **Commissioner requests.** A license holder must submit additional information requested by the commissioner that is necessary to meet statutory or federal funding requirements.

9530.6485 LICENSE HOLDERS SERVING ADOLESCENTS.

Subpart 1. **License holders serving adolescents.** A residential treatment program that serves persons under 18 years of age must be licensed as a residential program for children in out-of-home placement by the department unless the license holder is exempt under Minnesota Statutes, section 245A.03, subdivision 2.

Subp. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in part 9530.6450, subparts 1 and 5, an alcohol and drug counselor providing treatment services to adolescents must have:

A. an additional 30 hours of classroom instruction or one three-credit semester college course in adolescent development. This training need only be completed one time; and

B. at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.

Subp. 3. **Staffing 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 clients. It is the responsibility of the license holder to determine an acceptable group size based on the needs of the clients.

Subp. 4. **Academic program requirements.** Clients who are required to attend school must be enrolled and attending an educational program that has been approved by the Minnesota Department of Education.

Subp. 5. **Program requirements.** In addition to the requirements specified in the client's treatment plan under part 9530.6425, programs serving adolescents must include the following:

A. coordination with the school system to address the client's academic needs;

B. when appropriate, a plan that addresses the client's leisure activities without chemical use; and

C. a plan that addresses family involvement in the adolescent's treatment.

9530.6490 LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.

Subpart 1. **Health license requirements.** In addition to the requirements of parts 9530.6405 to 9530.6480, all license holders that offer supervision of children of clients are subject to the requirements of this part. License holders providing room and board for clients and their children must have an appropriate facility license from the Minnesota Department of Health.

Subp. 2. **Supervision of children defined.** "Supervision of children" means a caregiver is within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can intervene to protect the health and safety of the child. For the school age child it means a caregiver is available to help and care for the child so that the child's health and safety is protected.

Subp. 3. **Policy and schedule required.** License holders must meet the following requirements:

A. license holders must have a policy and schedule delineating the times and circumstances under which the license holder is responsible for supervision of children in the program and when the child's parents are responsible for child supervision. The policy must explain how the program will communicate its policy about child supervision responsibility to the parents; and

B. license holders must have written procedures addressing the actions to be taken by staff if children are neglected or abused including while the children are under the supervision of their parents.

Subp. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of children, the license holder must meet the following standards:

A. child and adult ratios in part 9502.0367;

B. day care training in Minnesota Statutes, section 245A.50;

C. behavior guidance in part 9502.0395;

D. activities and equipment in part 9502.0415;

E. physical environment in part 9502.0425; and

F. water, food, and nutrition in part 9502.0445, unless the license holder has a license from the Minnesota Department of Health.

9530.6495 LICENSE HOLDERS SERVING PERSONS WITH SUBSTANCE USE AND MENTAL HEALTH DISORDERS.

In addition to meeting the requirements of parts 9530.6405 to 9530.6490, license holders specializing in the treatment of persons with substance use disorder and mental health problems must:

A. demonstrate that staffing levels are appropriate for treating clients with substance use disorder and mental health problems, and that there is adequate staff with mental health training;

B. have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medications;

C. have a mental health professional available for staff supervision and consultation;

D. determine group size, structure, and content with consideration for the special needs of those with substance use disorder and mental health disorders;

E. have documentation of active interventions to stabilize mental health symptoms present in treatment plans and progress notes;

F. have continuing documentation of collaboration with continuing care mental health providers, and involvement of those providers in treatment planning meetings;

G. have available program materials adapted to individuals with mental health problems;

H. have policies that provide flexibility for clients who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping clients successfully complete treatment; and

I. have individual psychotherapy and case management available during the treatment process.

9530.6500 PROGRAMS SERVING INTRAVENOUS DRUG ABUSERS.

Subpart 1. **Additional requirements.** In addition to the requirements of parts 9530.6405 to 9530.6505, programs serving intravenous drug abusers must comply with the requirements of this part.

Subp. 2. **Capacity management and waiting list system compliance.** A program serving intravenous drug abusers must notify the department within seven days of when the program reaches both 90 and 100 percent of the program's capacity to care for clients. Each week, the program must report its capacity, current enrolled dosing clients, and any waiting list. A program reporting 90 percent of capacity must also notify the department when its census has increased or decreased from the 90 percent level.

Subp. 3. **Waiting list.** A program serving intravenous drug abusers must have a waiting list system. Each person seeking admission must be placed on the waiting list if the person cannot be admitted within 14 days of the date of application, unless the applicant is assessed by the program and found not to be eligible for admission according to parts 9530.6405 to 9530.6505, and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and Code of Federal Regulations, title 45, parts 160 to 164. The waiting list must assign a unique patient identifier for each intravenous drug abuser seeking treatment while awaiting admission. An applicant on a waiting list who receives no services under part 9530.6430, subpart 1, must not be considered a "client" as defined in part 9530.6405, subpart 8.

Subp. 4. **Client referral.** Programs serving intravenous drug abusers must consult the capacity management system so that persons on waiting lists are admitted at the earliest time to a program providing appropriate treatment within a reasonable geographic area. If the patient has been referred through a public payment system and if the program is not able to serve the client within 14 days of the date of application for admission, the program must contact and inform the referring agency of any available treatment capacity listed in the state capacity management system.

Subp. 5. **Outreach.** Programs serving intravenous drug abusers must carry out activities to encourage individuals in need of treatment to undergo treatment. The program's outreach model must:

A. select, train, and supervise outreach workers;

B. contact, communicate, and follow up with high risk substance abusers, their associates, and neighborhood residents within the constraints of federal and state confidentiality requirements, including Code of Federal Regulations, title 42, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;

C. promote awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV; and

D. recommend steps that can be taken to ensure that HIV transmission does not occur.

Subp. 6. **Central registry.** Programs serving intravenous drug abusers must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The client's failure to provide the information will prohibit involvement in an opiate treatment program. The information submitted must include the client's:

A. full name and all aliases;

B. date of admission;

C. date of birth;

D. Social Security number or INS number, if any;

E. enrollment status in other current or last known opiate treatment programs;

F. government-issued photo-identification card number; and

G. driver's license number, if any.

The information in items A to G must be submitted in a format prescribed by the commissioner, with the original kept in the client's chart, whenever a client is accepted for treatment, the client's type or dosage of a drug is changed, or the client's treatment is interrupted, resumed, or terminated.

9530.6505 REQUIREMENTS FOR LICENSED RESIDENTIAL TREATMENT.

Subpart 1. **Applicability.** A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program according to Minnesota Statutes, section 245A.02, subdivision 14, and is subject to this part.

Subp. 2. **Visitors.** Clients must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours, including both day and evening times. A client's right to receive visitors other than a personal physician, religious advisor, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided that limitations and the reasons for them are documented in the client's file. Clients must be allowed to receive visits at all reasonable times from their personal physicians, religious advisors, county case managers, parole or probation officers, and attorneys.

Subp. 3. **Client property management.** A license holder who provides room and board and treatment services to clients in the same facility, and any license holder that accepts client property must meet the requirements in Minnesota Statutes, section 245A.04, subdivision 13, for handling resident funds and property. In the course of client property management, license holders:

A. may establish policies regarding the use of personal property to assure that treatment activities and the rights of other patients are not infringed;

B. may take temporary custody of property for violation of facility policies;

C. must retain the client's property for a minimum of seven days after discharge if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and

D. must return all property held in trust to the client upon service termination regardless of the client's service termination status, except:

(1) drugs, drug paraphernalia, and drug containers that are forfeited under Minnesota Statutes, section 609.5316, must be destroyed by staff or given over to the custody of a local law enforcement agency, according to Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;

(2) weapons, explosives, and other property which can cause serious harm to self or others must be given over to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the right to reclaim any lawful property transferred; and

(3) medications that have been determined by a physician to be harmful after examining the client, except when the client's personal physician approves the medication for continued use.

Subp. 4. **Health facility license.** A license holder who provides room and board and treatment services in the same facility must have the appropriate license from the Department of Health.

Subp. 5. **Facility abuse prevention plan.** A license holder must establish and enforce an ongoing facility abuse prevention plan consistent with Minnesota Statutes, sections 245A.65 and 626.557, subdivision 14.

Subp. 6. **Individual abuse prevention plan.** A license holder must prepare an individual abuse prevention plan for each client as specified under Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14.

Subp. 7. **Health services.** License holders must have written procedures for assessing and monitoring client health, including a standardized data collection tool for collecting health-related information about each client. The policies and procedures must be approved and signed by a registered nurse.

Subp. 8. **Administration of medications.** License holders must meet the administration of medications requirements of part 9530.6435, subpart 3.